

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03838

3863

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5M 12 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore - 18</b>		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1804 East 29th Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ADELINE</b> Middle <b>AULHOUSE</b> Last <b>AULHOUSE</b>		4. DATE OF DEATH Month <b>4</b> Day <b>16</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/76</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George William Aulhouse</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Warner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction of the posterior left</b> <b>420.1</b> DUE TO <b>ventricle wall</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary artery thrombosis</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, depressed type</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/9/</b> , 19 <b>56</b> , to <b>4/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>56</b> , and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b>	
DATE SIGNED <b>4/16/56</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-19-1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Rd.</b>	
24a. REC'D BY REGISTRAR <b>18 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Karp</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03839

3864

## CERTIFICATE OF DEATH

Reg. Dist. No.

70

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>William</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 7, 1888</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John W. Baker</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Nusbaum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-12-7874</u>		17. INFORMANT <u>Harry E. Baker, Taneytown, Maryland R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Mar 25, 1956</u> , to <u>4-4-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Apr 2</u> , 19 <u>56</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>J. H. Legg</u> M.D. <u>Union Bridge Md-4-6-56</u> PHYSICIAN'S NAME (Type) <u>J. H. Legg M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Carroll, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Luss</u>				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>April 9/56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Etzel M. McKing</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03840

3865

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>Ynk -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>OLIVIA</b> Last <b>BAKER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/28/83</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>21</b> Hours <b>19</b> Min.	11. IF UNDER 24 HRS. Months <b>12</b> Days <b>21</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ynk -</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Graffton A. DuVall</b>		14. MOTHER'S MAIDEN NAME <b>Molly Peters</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephrosis due to remote infection</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>591X</b> (c) <b>591X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis</b>		19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/18</b> , 19 <b>56</b> , to <b>4/21</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>April 21</b> , 19 <b>56</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>Walther H. Sonnenfeldt</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 24 - 56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Trinidad</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey</b>		ADDRESS <b>Bethesda - Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 4-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Webb</b>	

BUREAU V. S.

APR 24 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3866

## CERTIFICATE OF DEATH

03841

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County **Carroll**  
 City or town **Silver Run**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **Yrs.**  
 Hospital, institution, or street address where death occurred:  
**Residence**  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Carroll**  
 City or town **Silver Run, Md.**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war **No.**

## 3. (a) FULL NAME

**Frederick Charles Bayner**

## 3. (b) Social Security Number

4. Sex **M** 5. Color or race **W** 6. (a) Single, married, widowed, or divorced **Widowed**  
 6. (b) Name of husband or wife **Mary Smith bayner**  
 7. Birth date of deceased (mo., day, yr.) **2/1/1872**  
 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years **84** Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace **Md.**  
 (Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

FATHER 12. Name **Godfred Bayner**  
 13. Birthplace \_\_\_\_\_

MOTHER 14. Maiden name **Unknown**  
 15. Birthplace \_\_\_\_\_

16. Informant **Mrs. Mildred Ireland**  
**Silver Run, Md.**  
 Address \_\_\_\_\_

17. **Burial** Date thereof **4/10/56**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
**Glen Haven**  
 Cemetery or crematory  
 Location **Balto.**

18. Funeral director **McCully Funeral Home**  
**130 E. Fort Ave.**  
 Address \_\_\_\_\_

19. **4-9** 19 **56** Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH **APRIL 7** 19 **56** at **9:00 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **DEC 15** 19 **55** to **APRIL 6** 19 **56**  
 and that I last saw him alive on **APRIL 6** 19 **56**

Immediate cause of death **1634 CA OF THE RT LUNG**  
 DURATION **12 mos.**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions **NUTRITIONAL ANEMIA**  
**ARTERIOCLEROTIC CARDIOVASCULAR**  
**RENAL DISEASE**  
 (Include pregnancy within 3 months of death) **2 mos**  
**YRS**

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

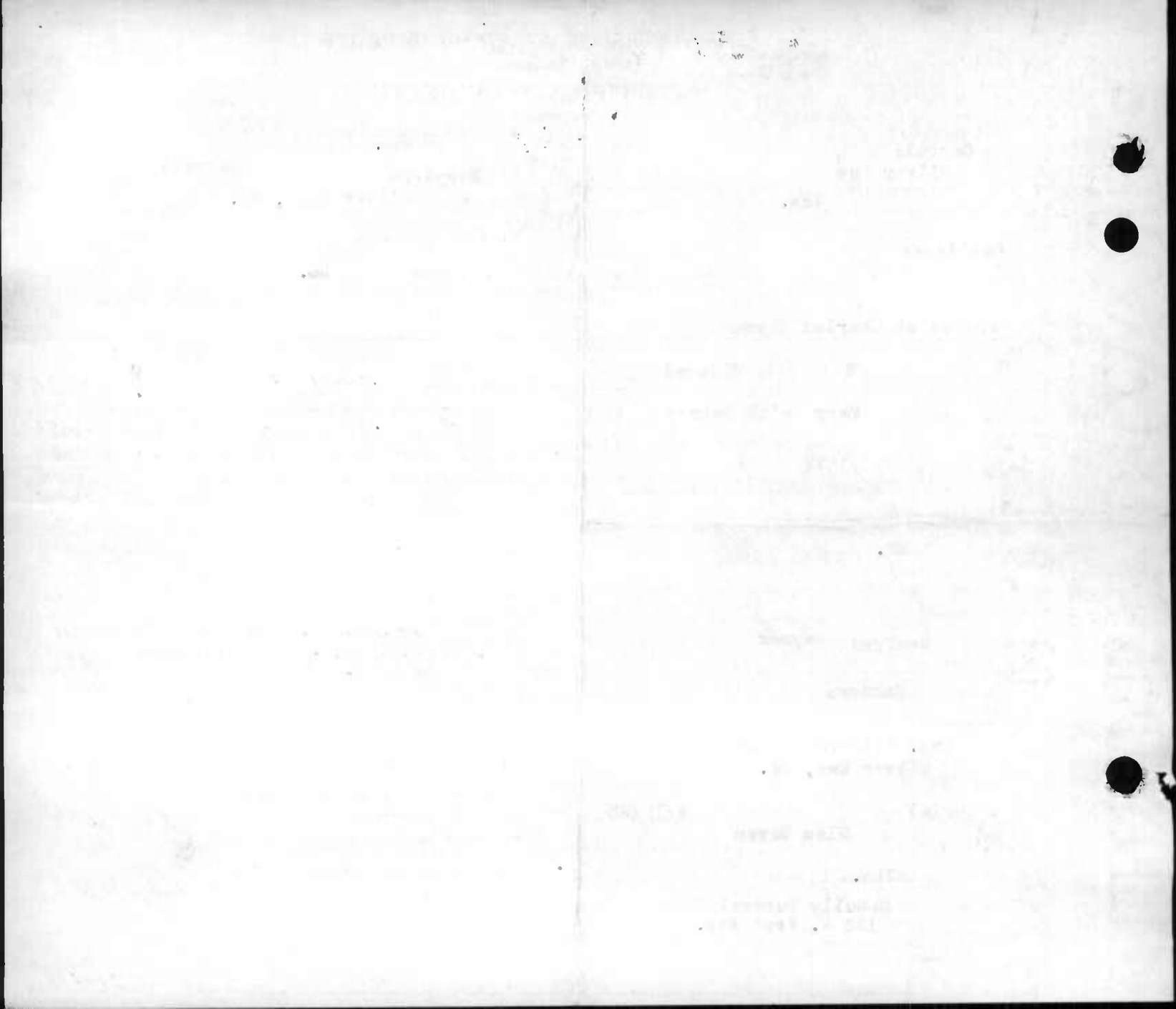
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE **Philip A. Zwick MD** M. D. or other

Address **Luthetown Pa** Date signed **4/7/56**



3867

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>79 years</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EUGENE CLIFTON BERRY</u>				4. DATE OF DEATH <u>April 9 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1877</u> <u>79</u> yrs.		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR
							Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Procurement - Retail Foodstore</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Berry</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Hayworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr E. L. Berry - Sykesville, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>PULMONARY EDEMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Dec. 55</u> <u>9 APR 1 56</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>DEC 1955</u> to <u>APR 11 1956</u> , that I last saw the deceased alive on <u>3 APR 11 1956</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville, MD</u> DATE SIGNED <u>4-9-56</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				SYKESVILLE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, MD</u>				24a. REC'D BY REGISTRAR <u>DATE 4-10-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weer</u>	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH	
1900		Maryland		1956		Baltimore, Maryland	
SEX		RACE		EDUCATION		OCCUPATION	
Male		White		High School		Teacher	
MARRIED		SINGLE		WIDOW		DIVORCED	
Yes		No		No		No	
CAUSE OF DEATH		MANNER OF DEATH		PERMANENT DAMAGE		TEMPORARY DAMAGE	
Heart Disease		Natural		No		No	
DISEASE		INJURY		POISON		OTHER	
Myocardial Infarction		None		None		None	
DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF EXAMINATION		PLACE OF EXAMINATION	
1956		Baltimore, Maryland		1956		Baltimore, Maryland	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
1956		1956		1956		1956	

RECEIVED  
APR 13 1956  
BUREAU V. B.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3868

## CERTIFICATE OF DEATH

03843

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b>				c. LENGTH OF STAY IN 1b <b>8mos. 9days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Amelia</b> Middle <b>Catherine</b> Last <b>Bish</b>				4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-18-1866</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ephrian Feeser</b>				14. MOTHER'S MAIDEN NAME <b>Sara Weibling</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT Address <b>Hospital Records - Sykesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with senile brain disease with psychotic reaction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State) -----	
21. I certify that I attended the deceased from <b>1-9-</b> , 19 <b>56</b> , to <b>4-12-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-12-</b> , 19 <b>56</b> , and that death occurred at <b>5:05 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital, Sykesville,</b> DATE SIGNED <b>4-12-56</b>							
ACTUAL SIGNATURE <b>Ilse Kamm, M.D.</b>				PHYSICIAN'S NAME (Type) <b>Ilse Kamm, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/14/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Little &amp; Son</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>Apr. 14, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Zeller</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]	
3. AGE [Illegible]		4. DATE OF BIRTH [Illegible]	
5. PLACE OF BIRTH [Illegible]		6. OCCUPATION [Illegible]	
7. MARITAL STATUS [Illegible]		8. CAUSE OF DEATH [Illegible]	
9. PLACE OF DEATH [Illegible]		10. TIME OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. DATE OF DEATH [Illegible]		14. PLACE OF DEATH [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
17. SIGNATURE OF WITNESS [Illegible]		18. SIGNATURE OF WITNESS [Illegible]	
19. SIGNATURE OF WITNESS [Illegible]		20. SIGNATURE OF WITNESS [Illegible]	
21. SIGNATURE OF WITNESS [Illegible]		22. SIGNATURE OF WITNESS [Illegible]	
23. SIGNATURE OF WITNESS [Illegible]		24. SIGNATURE OF WITNESS [Illegible]	
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59. SIGNATURE OF WITNESS [Illegible]		60. SIGNATURE OF WITNESS [Illegible]	
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71. SIGNATURE OF WITNESS [Illegible]		72. SIGNATURE OF WITNESS [Illegible]	
73. SIGNATURE OF WITNESS [Illegible]		74. SIGNATURE OF WITNESS [Illegible]	
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79. SIGNATURE OF WITNESS [Illegible]		80. SIGNATURE OF WITNESS [Illegible]	
81. SIGNATURE OF WITNESS [Illegible]		82. SIGNATURE OF WITNESS [Illegible]	
83. SIGNATURE OF WITNESS [Illegible]		84. SIGNATURE OF WITNESS [Illegible]	
85. SIGNATURE OF WITNESS [Illegible]		86. SIGNATURE OF WITNESS [Illegible]	
87. SIGNATURE OF WITNESS [Illegible]		88. SIGNATURE OF WITNESS [Illegible]	
89. SIGNATURE OF WITNESS [Illegible]		90. SIGNATURE OF WITNESS [Illegible]	
91. SIGNATURE OF WITNESS [Illegible]		92. SIGNATURE OF WITNESS [Illegible]	
93. SIGNATURE OF WITNESS [Illegible]		94. SIGNATURE OF WITNESS [Illegible]	
95. SIGNATURE OF WITNESS [Illegible]		96. SIGNATURE OF WITNESS [Illegible]	
97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF WITNESS [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

BUREAU V. S.

APR 17 1956

RECEIVED

03844

3869

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jacob</b>		4. DATE OF DEATH Month <b>April</b>	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 3, 1876</b>	
9. AGE (In years last birthday) <b>79</b>		10. IF UNDER 1 YEAR Months <b>23</b>	
11. IF UNDER 24 HRS. Hours <b>19</b>		12. IF UNDER 24 HRS. Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tin shop worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tinning</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>John Bittel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Schuchard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Old myocardial infarction</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis, simple deteriorati on</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While _____ Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Sept. 1st</b> 19 <b>47</b> , to <b>April 23</b> 19 <b>56</b> , that I last saw the deceased alive on <b>April 23</b> 19 <b>56</b> , and that death occurred at <b>10:55 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>4-25-56</b>			
ACTUAL SIGNATURE <b>Martin Gross</b>		M.D. <b>Sykesville, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Martin Gross, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/26/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS</b>		22d. LOCATION (City, town, or county) (State) <b>BROOKLYN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence F. Hoffmann</b>		24a. REC'D BY REGISTRAR <b>APR 27 1956</b>	
ADDRESS <b>3218 Hudson St</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Steer</b>	

0384

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

3873

2nd 1911

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		Jan 1, 1911		Baltimore, Md.		Baltimore, Md.		Heart disease		Jan 15, 1956		Baltimore, Md.		Dr. J. A. Smith		John Doe		John Doe	
13. Name of informant		14. Relationship		15. Signature of informant		16. Date of report		17. Signature of registrar		18. Date of registration		19. Signature of physician		20. Date of report		21. Signature of registrar		22. Date of registration		23. Signature of physician		24. Date of report	
John Doe		Son		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956	
25. Name of informant		26. Relationship		27. Signature of informant		28. Date of report		29. Signature of registrar		30. Date of registration		31. Signature of physician		32. Date of report		33. Signature of registrar		34. Date of registration		35. Signature of physician		36. Date of report	
John Doe		Son		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956		John Doe		Jan 15, 1956	

BUREAU V. S.

APR 27 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03845

3870

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>3601.4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>317 E. Lafayette Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Bosley</u> Last <u>Bosley</u>				4. DATE OF DEATH Month <u>April</u> , Day <u>7th</u> , Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1908</u>		9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B&amp;O Railroad Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Bossley</u>				14. MOTHER'S MAIDEN NAME <u>Ida Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records of Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> <u>350x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Parkinsonian Syndrome</u> DUE TO (c) <u>Status after lobotomy</u> 22 years INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with organic brain disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>February</u> , 19 <u>53</u> to <u>April 6th</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 6th</u> , 19 <u>56</u> , and that death occurred at <u>6:55a</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. Mastin</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville Md</u>			
DATE SIGNED <u>4/7/56</u>							
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO CITY</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Heedfeldt &amp; Son - Greenmount</u>				ADDRESS <u>  </u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>C. Harry Keen</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

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BUREAU V. S.

APR 10 1956

RECEIVED

3871

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>46 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Brown</b> Last <b>Brown</b>				4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1892</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Chestertown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Brown</b>				14. MOTHER'S MAIDEN NAME <b>Jane Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-2536</b>		17. INFORMANT Address <b>David Brown - Rt. 3, Chestertown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of prostate</b> <b>177x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Minimal pulmonary tuberculosis</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 1, 1956</b> , to <b>April 16, 1956</b> , that I last saw the deceased alive on <b>April 16, 1956</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T.F. Vestal</b>		M.D. <b>Henryton, Maryland</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>4-16-56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Tom F. Vestal</b>				<b>Henryton, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-21-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pomona Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Chestertown Route 3 Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. DeShell - Eastern Md</b>				24a. REC'D BY REGISTRAR DATE <b>4-16-56</b>		24b. REGISTRAR'S SIGNATURE <b>Albert R. Swankland</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 18 1956

RECEIVED

3872

CERTIFICATE OF DEATH

03847

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carrroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville - Rural.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Mansion Rest Home</b>		d. STREET ADDRESS <b>1139 W. Lombard St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Meda</b> Middle <b>Vernon</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>April</b> Day <b>7th</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 9, 1878</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Schlinkmann</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Chambers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>W. Roland Brown</b>	
17. INFORMANT <b>W. Roland Brown</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, middle meningeal artery, left</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>several years</b> <b>several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>18 February, 1956</b> , to <b>7 April, 1956</b> , that I last saw the deceased alive on <b>7 April, 1956</b> , and that death occurred at <b>2:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. H. Lawson, Jr.</b>		ADDRESS (Street, city or town, state) <b>Liberty Road at Eldersburg</b>	
DATE SIGNED <b>4/7/56</b>			
PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>		<b>Sykesville P.O., Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/10/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred. A. Cole</b>		ADDRESS <b>1913 W. Balto. St.</b>	
24a. REC'D BY REGISTRAR <b>DATE 9 1956</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Meier</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		Male		70		1885		Maryland		Baltimore		Maryland		United States	
MARRIAGE		SINGLE		MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
EDUCATION		SCHOOLING		COLLEGE		UNIVERSITY		DEGREE		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
OCCUPATION		PROFESSION		BUSINESS		MANUFACTURING		INDUSTRY		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
RELIGION		RACE		COLOR		HEIGHT		WEIGHT		EYES		HAIR		SKIN	
None		White		White		5' 10"		170		Blue		Brown		Fair	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		CITY		STATE		COUNTRY	
None		None		None		None		None		None		None		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
None		None		None		None		None		None		None		None	

BUREAU V. S.

APR 9 1956

RECEIVED

3873

CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 2, Pa. Im 296, 4/30/56 mb

1. PLACE OF DEATH: COUNTY <u>Carroll</u> MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Woodbine</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodbine</u> Rt.#1 STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) <u>NELSON</u> (Middle) <u>A</u> (Last) <u>CARR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>4</u> <u>4</u> <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>9/12/1880</u>
9. AGE last birthday: <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>7</u> Hours <u>1</u> Min.	
11. BIRTHPLACE (State or foreign country): <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William T. Carr</u>		14. MOTHER'S MAIDEN NAME: <u>Addie Palmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Laura C. Carr, Woodbine, Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>1 hr</u>	
ANTECEDENT CAUSE (B) <u>Chn - Extensive Sclerosis</u>		<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chn. Mitral regurgitation</u>		<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 10, 1956</u> to <u>April 4, 1956</u> , that I last saw the deceased alive on <u>April 4, 1956</u> and that death occurred at <u>Lot M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Shirley Barr</u> M.D.		ADDRESS <u>Westminster, Md</u> DATE SIGNED <u>4/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/7/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery, Suitland, Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>E. Pearl Manning</u>	
24. FUNERAL DIRECTOR <u>Nalley, Funeral Home</u>		ADDRESS <u>3200-R. 2 Ave Mt Rainier, Md</u>	

APR 25 1956

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03849

3874

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>42Y 9M 15D</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANGELOS</b> Middle <b>CHALDIS</b> Last <b>CHALDIS</b>				4. DATE OF DEATH Month <b>4</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Greece</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Greece-4683162</b>				13. FATHER'S NAME <b>unknown</b>			
14. MOTHER'S MAIDEN NAME <b>unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT <b>Record, Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic glomerulonephritis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malignant hypertension</b> DUE TO (c) <b>Schizophrenic reaction, catatonic type, long-standing</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>4/18</b> , 19 <b>56</b> , to <b>4/22</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/22</b> , 19 <b>56</b> , and that death occurred at <b>2:55 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b>			
DATE SIGNED <b>4/23/56</b>							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>4/24/56</b>		<b>Forest Hill</b>		<b>German Hill Road</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. J. Lacey Sons</b>				ADDRESS <b>1318 Light</b>		24a. REC'D BY REGISTRAR <b>DATE 24 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. J. Hays</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts and circumstances attending the death of the person named above, and that the same was caused by the disease or injury stated.		I, the undersigned, being a duly qualified physician, do hereby certify that the above is a true and correct statement of the facts and circumstances attending the death of the person named above, and that the same was caused by the disease or injury stated.	
Name of deceased: <b>JOHN J. SMITH</b> Date of birth: <b>1885-10-15</b> Sex: <b>Male</b> Race: <b>White</b> Marital status: <b>Married</b> Occupation: <b>Engineer</b> Usual residence: <b>1234 Main St., Baltimore, Md.</b> Date of death: <b>1955-04-24</b> Place of death: <b>Home</b> Cause of death: <b>Heart disease</b> Immediate cause: <b>Myocardial infarction</b> Underlying cause: <b>Atherosclerosis of coronary arteries</b> Contributing causes: <b>Hypertension, Diabetes mellitus</b> Manner of death: <b>Natural</b> Signature of physician: <b>Dr. J. H. Jones</b> Signature of registrar: <b>John A. Smith</b> Date: <b>April 24, 1955</b>		Name of deceased: <b>JOHN J. SMITH</b> Date of birth: <b>1885-10-15</b> Sex: <b>Male</b> Race: <b>White</b> Marital status: <b>Married</b> Occupation: <b>Engineer</b> Usual residence: <b>1234 Main St., Baltimore, Md.</b> Date of death: <b>1955-04-24</b> Place of death: <b>Home</b> Cause of death: <b>Heart disease</b> Immediate cause: <b>Myocardial infarction</b> Underlying cause: <b>Atherosclerosis of coronary arteries</b> Contributing causes: <b>Hypertension, Diabetes mellitus</b> Manner of death: <b>Natural</b> Signature of physician: <b>Dr. J. H. Jones</b> Signature of registrar: <b>John A. Smith</b> Date: <b>April 24, 1955</b>	

**RECEIVED**  
**BUREAU V. 8**  
**APR 24 1955**

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

3875

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RURAL MONTHS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLOVER NURSING HOME</u>				d. STREET ADDRESS <u>LINWOOD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IDA VIRGINIA CRABBS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 11 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 26 - 1867</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN SLIMMER</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET SLIMMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>RALPH M CRABBS LINWOOD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral softening</u> <u>332X</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>9049</u> (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs 2 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture surgical neck left thigh</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.) <u>in motor car</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 20, 1956</u> to <u>Apr 11, 1956</u> , that I last saw the deceased alive on <u>Apr 11, 1956</u> , and that death occurred at <u>7 P M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Reese Wilkens</u>				DATE SIGNED <u>Apr 11 1956</u>			
PHYSICIAN'S NAME (Type) <u>E. REESE</u>				ADDRESS (Street, city or town, state) <u>Westminster Ter 4 1/2</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 14 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W D Hartzler &amp; Sons</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4-13-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harold Wulter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		11-1-28		MEMPHIS, TENN.		4-4-68		MEMPHIS, TENN.		HEART DISEASE		SUICIDE		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		METHODIST		MARRIED		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

APR 16 1956

RECEIVED

17E 11E

3876  
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marriottsville</b>			c. LENGTH OF STAY IN 1b <b>25 years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>Marriottsville</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>CUSTIS</b> Last			4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>19 56</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-1898</b>		9. AGE (In years last birthday) <b>57 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Catonsville, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Howard Robinson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Tyler</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT Address <b>Marie Custis Marriottsville, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>hypertensive cardiovascular disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1935</b> , 19____, to <b>16 April, 1956</b> , that I last saw the deceased alive on <b>15 April, 1956</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Liberty Road at Eldersburg 4-16-56</b>					
ACTUAL SIGNATURE <b>Wm. H. Lawson, Jr.</b>		M.D. <b>Liberty Road at Eldersburg 4-16-56</b>			
PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr. M.D.</b>		<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4-22-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Liberty</b>		22d. LOCATION (City, town, or county) (State) <b>Alpha, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>			24a. REC'D BY REGISTRAR DATE <b>4-17-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BUREAU V. S.

## CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		65		1890		Baltimore		Baltimore		Baltimore		Maryland	
MARRIAGE		MARRIED		DATE		PLACE		CITY		COUNTY		STATE			
MARRIED		MARRIED		1915		Baltimore		Baltimore		Baltimore		Maryland			
OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION		OCCUPATION	
Retired		Retired		Retired		Retired		Retired		Retired		Retired		Retired	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease		Heart Disease	
DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE		DISEASE	
Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction		Myocardial Infarction	
DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH		DATE OF DEATH	
April 23, 1956		April 23, 1956		April 23, 1956		April 23, 1956		April 23, 1956		April 23, 1956		April 23, 1956		April 23, 1956	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
Home		Home		Home		Home		Home		Home		Home		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

APR 23 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3877

## CERTIFICATE OF DEATH

03852

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11Y 2M 16 D</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>712 Gladstone Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>LUCIA</b> Middle Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>4</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/7/80</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher &amp; Social Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Caleb S. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Blackman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Secondary Anemia; Schizophrenic reaction, paranoid type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/16</b> , 19 <b>55</b> , to <b>4/5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/1</b> , 19 <b>56</b> , and that death occurred at <b>3:00</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/5/56</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 7. 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC</b> <b>Baltimore Md.</b>		24a. REC'D BY REGISTRAR <b>Henry F. Sander</b> DATE <b>9 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Key</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8877

1. NAME OF DECEASED JAMES E. SMITH		2. SEX Male		3. AGE 45		4. RACE White		5. DATE OF BIRTH 1911		6. PLACE OF BIRTH Baltimore, Md.	
7. NAME OF DECEASED JAMES E. SMITH		8. SEX Male		9. AGE 45		10. RACE White		11. DATE OF BIRTH 1911		12. PLACE OF BIRTH Baltimore, Md.	
13. NAME OF DECEASED JAMES E. SMITH		14. SEX Male		15. AGE 45		16. RACE White		17. DATE OF BIRTH 1911		18. PLACE OF BIRTH Baltimore, Md.	
19. NAME OF DECEASED JAMES E. SMITH		20. SEX Male		21. AGE 45		22. RACE White		23. DATE OF BIRTH 1911		24. PLACE OF BIRTH Baltimore, Md.	
25. NAME OF DECEASED JAMES E. SMITH		26. SEX Male		27. AGE 45		28. RACE White		29. DATE OF BIRTH 1911		30. PLACE OF BIRTH Baltimore, Md.	
31. NAME OF DECEASED JAMES E. SMITH		32. SEX Male		33. AGE 45		34. RACE White		35. DATE OF BIRTH 1911		36. PLACE OF BIRTH Baltimore, Md.	
37. NAME OF DECEASED JAMES E. SMITH		38. SEX Male		39. AGE 45		40. RACE White		41. DATE OF BIRTH 1911		42. PLACE OF BIRTH Baltimore, Md.	
43. NAME OF DECEASED JAMES E. SMITH		44. SEX Male		45. AGE 45		46. RACE White		47. DATE OF BIRTH 1911		48. PLACE OF BIRTH Baltimore, Md.	
49. NAME OF DECEASED JAMES E. SMITH		50. SEX Male		51. AGE 45		52. RACE White		53. DATE OF BIRTH 1911		54. PLACE OF BIRTH Baltimore, Md.	
55. NAME OF DECEASED JAMES E. SMITH		56. SEX Male		57. AGE 45		58. RACE White		59. DATE OF BIRTH 1911		60. PLACE OF BIRTH Baltimore, Md.	
61. NAME OF DECEASED JAMES E. SMITH		62. SEX Male		63. AGE 45		64. RACE White		65. DATE OF BIRTH 1911		66. PLACE OF BIRTH Baltimore, Md.	
67. NAME OF DECEASED JAMES E. SMITH		68. SEX Male		69. AGE 45		70. RACE White		71. DATE OF BIRTH 1911		72. PLACE OF BIRTH Baltimore, Md.	
73. NAME OF DECEASED JAMES E. SMITH		74. SEX Male		75. AGE 45		76. RACE White		77. DATE OF BIRTH 1911		78. PLACE OF BIRTH Baltimore, Md.	
79. NAME OF DECEASED JAMES E. SMITH		80. SEX Male		81. AGE 45		82. RACE White		83. DATE OF BIRTH 1911		84. PLACE OF BIRTH Baltimore, Md.	
85. NAME OF DECEASED JAMES E. SMITH		86. SEX Male		87. AGE 45		88. RACE White		89. DATE OF BIRTH 1911		90. PLACE OF BIRTH Baltimore, Md.	
91. NAME OF DECEASED JAMES E. SMITH		92. SEX Male		93. AGE 45		94. RACE White		95. DATE OF BIRTH 1911		96. PLACE OF BIRTH Baltimore, Md.	
97. NAME OF DECEASED JAMES E. SMITH		98. SEX Male		99. AGE 45		100. RACE White		101. DATE OF BIRTH 1911		102. PLACE OF BIRTH Baltimore, Md.	
103. NAME OF DECEASED JAMES E. SMITH		104. SEX Male		105. AGE 45		106. RACE White		107. DATE OF BIRTH 1911		108. PLACE OF BIRTH Baltimore, Md.	
109. NAME OF DECEASED JAMES E. SMITH		110. SEX Male		111. AGE 45		112. RACE White		113. DATE OF BIRTH 1911		114. PLACE OF BIRTH Baltimore, Md.	
115. NAME OF DECEASED JAMES E. SMITH		116. SEX Male		117. AGE 45		118. RACE White		119. DATE OF BIRTH 1911		120. PLACE OF BIRTH Baltimore, Md.	
121. NAME OF DECEASED JAMES E. SMITH		122. SEX Male		123. AGE 45		124. RACE White		125. DATE OF BIRTH 1911		126. PLACE OF BIRTH Baltimore, Md.	
127. NAME OF DECEASED JAMES E. SMITH		128. SEX Male		129. AGE 45		130. RACE White		131. DATE OF BIRTH 1911		132. PLACE OF BIRTH Baltimore, Md.	
133. NAME OF DECEASED JAMES E. SMITH		134. SEX Male		135. AGE 45		136. RACE White		137. DATE OF BIRTH 1911		138. PLACE OF BIRTH Baltimore, Md.	
139. NAME OF DECEASED JAMES E. SMITH		140. SEX Male		141. AGE 45		142. RACE White		143. DATE OF BIRTH 1911		144. PLACE OF BIRTH Baltimore, Md.	
145. NAME OF DECEASED JAMES E. SMITH		146. SEX Male		147. AGE 45		148. RACE White		149. DATE OF BIRTH 1911		150. PLACE OF BIRTH Baltimore, Md.	
151. NAME OF DECEASED JAMES E. SMITH		152. SEX Male		153. AGE 45		154. RACE White		155. DATE OF BIRTH 1911		156. PLACE OF BIRTH Baltimore, Md.	
157. NAME OF DECEASED JAMES E. SMITH		158. SEX Male		159. AGE 45		160. RACE White		161. DATE OF BIRTH 1911		162. PLACE OF BIRTH Baltimore, Md.	
163. NAME OF DECEASED JAMES E. SMITH		164. SEX Male		165. AGE 45		166. RACE White		167. DATE OF BIRTH 1911		168. PLACE OF BIRTH Baltimore, Md.	
169. NAME OF DECEASED JAMES E. SMITH		170. SEX Male		171. AGE 45		172. RACE White		173. DATE OF BIRTH 1911		174. PLACE OF BIRTH Baltimore, Md.	
175. NAME OF DECEASED JAMES E. SMITH		176. SEX Male		177. AGE 45		178. RACE White		179. DATE OF BIRTH 1911		180. PLACE OF BIRTH Baltimore, Md.	
181. NAME OF DECEASED JAMES E. SMITH		182. SEX Male		183. AGE 45		184. RACE White		185. DATE OF BIRTH 1911		186. PLACE OF BIRTH Baltimore, Md.	
187. NAME OF DECEASED JAMES E. SMITH		188. SEX Male		189. AGE 45		190. RACE White		191. DATE OF BIRTH 1911		192. PLACE OF BIRTH Baltimore, Md.	
193. NAME OF DECEASED JAMES E. SMITH		194. SEX Male		195. AGE 45		196. RACE White		197. DATE OF BIRTH 1911		198. PLACE OF BIRTH Baltimore, Md.	
199. NAME OF DECEASED JAMES E. SMITH		200. SEX Male		201. AGE 45		202. RACE White		203. DATE OF BIRTH 1911		204. PLACE OF BIRTH Baltimore, Md.	

BUREAU V. S.

APR 9 1956

RECEIVED

3878

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Marriottville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Marriottville</u>			
c. LENGTH OF STAY in 1b <u>30 years</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridge &amp; Marriottville Roads</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>HILDA</u> Middle <u>SUSAN</u> Last <u>DAY</u>				4. DATE OF DEATH Month <u>April</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 29, 1902</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Kathryn Bowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. Lawrence T. Day, Jr. Marriottville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Cerebral Hemorrhage, rt. middle meningeal artery.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>hypertensive cardiovascular disease</u> DUE TO <u>15 yrs.</u> (c) <u>general arteriosclerosis</u> DUE TO <u>15 yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1935</u> , 19____, to <u>10 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 April</u> , 19 <u>56</u> , and that death occurred at <u>8:00 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>L. H. Lawson</u>				M.D. <u>Liberty Road at Eldersburg</u> <u>4-12-56</u>			
PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M.D.</u>				<u>Sykesville P.O., Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-13-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weir</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3528

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is filled out with handwritten text.

BUREAU-V. S.

APR 17 1950

RECEIVED

3858

## CERTIFICATE OF DEATH

03854

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 KEMPER AVE.</u>		d. STREET ADDRESS <u>10 KEMPER AVE.</u>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>EMILY</u> Last <u>DERR</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-23, 1874</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALBERT T. FOWLER</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E. KELLY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-01-0498</u>	
17. INFORMANT <u>THEODORE F. DERR</u>		Address <u>10 KEMPER AVE. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension &amp; Cardiovascular Disease</u> DUE TO (c) <u>10400</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4/27/56</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 27, 1956</u> , to <u>April 30, 1956</u> , that I last saw the deceased alive on <u>April 29, 1956</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter Speicher</u>		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Walter Speicher</u>		DATE SIGNED <u>5/1/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 3, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER GEN.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Bankard &amp; Son</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 4 1956

BUREAU V. 3

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. EDUCATION		9. RELIGION		10. RACE		11. COLOR		12. HEIGHT		13. WEIGHT		14. BUILD		15. HAIR		16. EYES		17. SKIN		18. TENDRILS		19. TEETH		20. NAILS		21. FINGERPRINTS		22. SIGNATURE		23. ADDRESS		24. CITY		25. STATE		26. ZIP		27. COUNTY		28. DISTRICT		29. WARD		30. PARISH		31. TOWNSHIP		32. RANGE		33. SECTION		34. QUARTER		35. LOT		36. BLOCK		37. TRACT		38. SUBDIVISION		39. PLAT		40. BOOK		41. PAGE		42. INSTRUMENT		43. DATE		44. TIME		45. PLACE		46. METHOD		47. INSTRUMENT		48. DATE		49. TIME		50. PLACE		51. METHOD		52. INSTRUMENT		53. DATE		54. TIME		55. PLACE		56. METHOD		57. INSTRUMENT		58. DATE		59. TIME		60. PLACE		61. METHOD		62. INSTRUMENT		63. DATE		64. TIME		65. PLACE		66. METHOD		67. INSTRUMENT		68. DATE		69. TIME		70. PLACE		71. METHOD		72. INSTRUMENT		73. DATE		74. TIME		75. PLACE		76. METHOD		77. INSTRUMENT		78. DATE		79. TIME		80. PLACE		81. METHOD		82. INSTRUMENT		83. DATE		84. TIME		85. PLACE		86. METHOD		87. INSTRUMENT		88. DATE		89. TIME		90. PLACE		91. METHOD		92. INSTRUMENT		93. DATE		94. TIME		95. PLACE		96. METHOD		97. INSTRUMENT		98. DATE		99. TIME		100. PLACE		101. METHOD		102. INSTRUMENT		103. DATE		104. TIME		105. PLACE		106. METHOD		107. INSTRUMENT		108. DATE		109. TIME		110. PLACE		111. METHOD		112. INSTRUMENT		113. DATE		114. TIME		115. PLACE		116. METHOD		117. INSTRUMENT		118. DATE		119. TIME		120. PLACE		121. METHOD		122. INSTRUMENT		123. DATE		124. TIME		125. PLACE		126. METHOD		127. INSTRUMENT		128. DATE		129. TIME		130. PLACE		131. METHOD		132. INSTRUMENT		133. DATE		134. TIME		135. PLACE		136. METHOD		137. INSTRUMENT		138. DATE		139. TIME		140. PLACE		141. METHOD		142. INSTRUMENT		143. DATE		144. TIME		145. PLACE		146. METHOD		147. INSTRUMENT		148. DATE		149. TIME		150. PLACE		151. METHOD		152. INSTRUMENT		153. DATE		154. TIME		155. PLACE		156. METHOD		157. INSTRUMENT		158. DATE		159. TIME		160. PLACE		161. 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DATE		859. TIME		860. PLACE		861. METHOD		862. INSTRUMENT		863. DATE		864. TIME		865. PLACE		866. METHOD		867. INSTRUMENT		868. DATE		869. TIME		870. PLACE		871. METHOD		872. INSTRUMENT		873. DATE		874. TIME		875. PLACE		876. METHOD		877. INSTRUMENT		878. DATE		879. TIME		880. PLACE		881. METHOD		882. INSTRUMENT		883. DATE		884. TIME		885. PLACE		886. METHOD		887. INSTRUMENT		888. DATE		889. TIME		890. PLACE		891. METHOD		892. INSTRUMENT		893. DATE		894. TIME		895. PLACE		896. METHOD		897. INSTRUMENT		898. DATE		899. TIME		900. PLACE		901. METHOD		902. INSTRUMENT		903. DATE		904. TIME		905. PLACE		906. METHOD		907. INSTRUMENT		908. DATE		909. TIME		910. PLACE		911. METHOD		912. INSTRUMENT		913. DATE		914. TIME		915. PLACE		916. METHOD		917. INSTRUMENT		918. DATE		919. TIME		920. PLACE		921. METHOD		922. INSTRUMENT		923. DATE		924. TIME		925. PLACE		926. METHOD		927. INSTRUMENT		928. DATE		929. TIME		930. PLACE		931. METHOD		932. INSTRUMENT		9	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3879

CERTIFICATE OF DEATH

03855/1

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>UNION BRIDGE</b>				c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FARQUHAR ST.</b>				e. STREET ADDRESS <b>FARQUHAR ST.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM WALTER DONELSON</b>				4. DATE OF DEATH Month Day Year <b>APRIL 8 1956</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 9-1888</b>	9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MAINTENANCE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTEMUS DONELSON</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA BAUB LITZ</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-05-9862</b>		17. INFORMANT Address <b>MD BALTIMORE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X Cerebral hemorrhage</b> DUE TO (b) <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to <b>4-8-1956</b> , that I last saw the deceased alive on <b>4-8-1956</b> , and that death occurred at <b>1:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Union Bridge</b> DATE SIGNED <b>7-8-56</b>							
ACTUAL SIGNATURE <b>J. H. Legg</b> M.D.				PHYSICIAN'S NAME (Type) <b>T. H. LEGG M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>APR 11-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BEAVER DAM</b>		22d. LOCATION (City, town, or county) (State) <b>FREDERICK CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>D D HARTZLER &amp; SONS</b> ADDRESS <b>UNION BRIDGE MD</b>				24a. REC'D BY REGISTRAR <b>4/10/56</b>		24b. REGISTRAR'S SIGNATURE <b>Leslie J. Roberts</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES EARL RAY		M		35		W		1921		MOBILE, ALABAMA		APR 4 1968		MEMPHIS, TENNESSEE		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. MARITAL STATUS		15. EDUCATION		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		MARRIED		HIGH SCHOOL		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	

BUREAU V. S.

APR 12 1968

RECEIVED

TO ATTORNEY OF  
JAMES EARL RAY  
FBI - MEMPHIS  
APR 12 1968

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3880

CERTIFICATE OF DEATH

038586

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hales Age Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frederick Dorsey Ensor</b>		4. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 5, 1867</b>
9. AGE (In years last birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George Ensor</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Jos. Bublovack, 4417 Belview Ave. Balto.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis - Chronic</b> <b>422.1</b> DUE TO <b>Decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis - (general)</b> DUE TO <b>marked cerebral</b> (c) <b>marked cerebral</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1930</b> to <b>4-24-56</b> , that I last saw the deceased alive on <b>4-22-56</b> , and that death occurred at <b>7:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Saffell</b>		ADDRESS (Street, city or town, state) <b>Reisterstown, Md.</b>	
PHYSICIAN'S NAME (Type) <b>James G. Saffell M.D.</b>		DATE SIGNED <b>May 4 25-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>April 27/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24. REC'D BY REGISTRAR DATE <b>4-25-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Harriet Muller</b>			

CERTIFICATE OF DEATH

1886

<p>1. Name of deceased: <u>John Doe</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Age: <u>45</u></p>		<p>4. Date of death: <u>April 27, 1956</u></p>	
<p>5. Place of death: <u>Home</u></p>		<p>6. Cause of death: <u>Heart Disease</u></p>	
<p>7. Immediate cause: <u>Myocardial Infarction</u></p>		<p>8. Underlying cause: <u>Coronary Artery Disease</u></p>	
<p>9. Contributing cause: <u>None</u></p>		<p>10. Manner of death: <u>Natural</u></p>	
<p>11. Signature of physician: <u>[Signature]</u></p>		<p>12. Signature of registrar: <u>[Signature]</u></p>	
<p>13. Date of registration: <u>April 27, 1956</u></p>		<p>14. Office of registration: <u>Baltimore</u></p>	

BUREAU V. 3

APR 27 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03857

## 3881 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Canoe</i>		MARYLAND		STATE <i>Ind</i>		COUNTY <i>Canoe</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Manchester</i>		LENGTH OF STAY (in this place) <i>1 yr</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Long's View Nursing Home</i>				STREET ADDRESS (If rural give location) <i>127 N Main St</i>			
3. NAME OF DECEASED (Type or Print) <i>Bertie V. Folk</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>4-30-56</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>	8. DATE OF BIRTH <i>11/22/83</i>	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		11. BIRTHPLACE (State or foreign country) <i>Canoe Co Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Folk</i>				14. MOTHER'S MAIDEN NAME <i>Martha Lawson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT & ADDRESS <i>Charles H Folk</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>420.0 Arteriosclerotic Heart Disease with congestive heart failure</i>						<i>5 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</i>							
DUE TO (C) <i>Atelectasis of rt lower lobe of lung</i>						<i>3 wks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>June 1948</i> to <i>April 30 1956</i> , that I last saw the deceased alive on <i>4/30/56</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>W. H. Ford</i>		M. D.		ADDRESS (Street, city, town, state) <i>Manchester, Md.</i>		DATE SIGNED <i>4/30/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>5-3-56</i>		NAME OF CEMETERY OR CREMATORY <i>Lincoln</i>		LOCATION (City, town, or county) (State) <i>Canoe Md</i>	
24. REC'D BY REGISTRAR <i>apv. 30/56</i>		REGISTRAR'S SIGNATURE <i>Mrs. W. S. Denno</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Fredrick Buckner</i>		ADDRESS <i>Harrods</i>	

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3882 **CERTIFICATE OF DEATH**

03858

Reg. Dist. No. 78

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>rural-Westminster</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural --Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Taylorsville</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>CARRIE S. FRANKLIN</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>April 27 19 56</u>			
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widowed</u>	<b>8. DATE OF BIRTH</b> <u>2-10-1883</u>		<b>9. AGE last birthday</b> <u>73</u> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>----</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
<b>13. FATHER'S NAME</b> <u>Ezra Wantz</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Belinda Brown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Union Bridge</u> <u>Mrs. Belinda Pittinger, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>4222 IMMEDIATE CAUSE (A)</b> <u>CHRONIC MYOCARDITIS</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>FATTY DEGENERATION</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 10, 19 56</u>, to <u>April 27, 19 56</u>, that I last saw the deceased alive on <u>April 24, 19 56</u>, and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>T. H. Legg</u>		<b>M.D.</b> <u>Union Bridge Md</u>		<b>ADDRESS (Street, city, town, state)</b> <u>4-28-57</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>4-30-1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Kriders</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Westminster, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>April -30-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>E. M. Farver</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C. M. Waltz</u>		<b>ADDRESS</b> <u>Winfield, Md.</u>	

# 1988 CERTIFICATE OF DEATH

118800

West Coast 100

ALL INFORMATION HEREON IS UNCLASSIFIED

DATE OF DEATH: 10/15/88

PLACE OF DEATH: Baltimore, Maryland

DATE OF BIRTH: 10/15/88

PLACE OF BIRTH: Baltimore, Maryland

DATE OF DEATH: 10/15/88

PLACE OF DEATH: Baltimore, Maryland

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DATE OF BIRTH: 10/15/88

PLACE OF BIRTH: Baltimore, Maryland

BUREAU V. 2

MAY 1 1956

RECEIVED

3883

## CERTIFICATE OF DEATH

Reg. Dist. No. *82-83*

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural--Mt. Airy</b>				c. LENGTH OF STAY IN 1b <b>47 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Ridgeville</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>R. HARVEY GREEN</b>				4. DATE OF DEATH Month Day Year <b>April 30, 1956</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-2-1885</b>		9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grower</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ridgeville Nurseries</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Alfred Green</b>				14. MOTHER'S MAIDEN NAME <b>Margaret McSherry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-09-8476</b>		17. INFORMANT Address <b>Mrs. Etta Green, Mt. Airy, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach &amp; Liver</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 14, 1956</b> , to <b>Apr. 30, 1956</b> , that I last saw the deceased alive on <b>Apr. 30, 1956</b> , and that death occurred at <b>4:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. M. VanPoole</b>		M.D.		ADDRESS (Street, city or town, state) <b>Mt. Airy, Md.</b>		DATE SIGNED <b>4-30-56</b>	
PHYSICIAN'S NAME (Type) <b>C. M. VanPoole</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5-3-1956</b>		22c. NAME OF CEMETERY OR CREMATOR <b>Pine Grove</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz</b>		ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5-3-56</b>		24b. REGISTRAR'S SIGNATURE <b>Robert R. Hunt</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• 516 • JOURNAL OF DOCUMENTATION

3859

## CERTIFICATE OF DEATH

03860

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>63 Liberty St.</b>				d. STREET ADDRESS <b>63 Liberty St.</b>			
3. NAME OF DECEASED (Type or print) <b>CARRIE ELIZABETH GRIMES</b>				4. DATE OF DEATH Month <b>April</b> Day <b>4</b> Year <b>1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-18-1877</b>		9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alfred Linton</b>				14. MOTHER'S MAIDEN NAME <b>Dora Frost</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Miss Esther Grimes,</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b> <b>260x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension &amp; Arterio sclerosis</b> DUE TO (c) <b>diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>5 yrs</b> <b>10-15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March</b> , 1953 to <b>April 4</b> , 1956, that I last saw the deceased alive on <b>April 4</b> , 1956, and that death occurred at <b>10:30 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. Glenn Speicher</b> M.D.				ADDRESS (Street, city or town, state) <b>Westminster Md</b> DATE SIGNED <b>April 5-1956</b>			
PHYSICIAN'S NAME (Type) <b>W. Glenn Speicher</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-7-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bethesda</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. M. Watz</b>				ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>4-7-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Harold Miller</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after the death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5521-31-1

BUREAU V. 5.

APR 10 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 45C 7-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03861

3884

## CERTIFICATE OF DEATH

Reg. Dist. No. *50*

1. PLACE OF DEATH <i>New Windsor</i>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Leannell</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Leannell</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>New Windsor</i>		LENGTH OF STAY (in this place) <i>Life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>New Windsor</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <i>P.D. 2</i> (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>EFFIE LOUISE HAINES</i> (First) (Middle) (Last)				4. DATE OF DEATH <i>Apr 24</i> (Month) (Day) (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>7-19-1868</i>	9. AGE last birthday <i>87</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Diebe</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Ann Haines</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>m</i> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS <i>Arthur Haines</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Arterio sclerotic Cardiovascular disease</i>						<i>Years</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Apr 20</i> , 19 <i>56</i> , to <i>Apr 24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Apr 20</i> , 19 <i>56</i> , and that death occurred at <i>7 A</i> .M., from the causes and on the date stated above.							
SIGNATURE <i>James J. March</i>				ADDRESS (Street, city, town, state) <i>M.D. Westminster Md</i>		DATE SIGNED <i>Apr 25/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		DATE THEREOF <i>4-27-56</i>		NAME OF CEMETERY OR CREMATORY <i>PIPE CREEK CEM</i>		LOCATION (City, town, or county) (State) <i>UNIONTOWN Md.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Conrad Bredel</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>K. BAYHARD + Son</i>		ADDRESS <i>WESTMINSTER</i>	
DATE <i>Apr 26/56</i>							

# CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF DECEASED

12. SIGNATURE OF NEXT OF KIN

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BUREAU V. S.

APR 30 1956

RECEIVED

ENCLOSURE 3-11

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF DEATH  
5. PLACE OF DEATH  
6. CAUSE OF DEATH  
7. MANNER OF DEATH  
8. SIGNATURE OF PHYSICIAN  
9. SIGNATURE OF REGISTRAR  
10. SIGNATURE OF WITNESSES  
11. SIGNATURE OF DECEASED  
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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G195 1-16-56 et

3885

## CERTIFICATE OF DEATH

03862

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mazie</u> Middle <u>---</u> Last <u>Halligan</u>			4. DATE OF DEATH Month <u>4</u> Day <u>4</u> Year <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>		9. AGE (In years last birthday) <u>85 (?)</u> yrs.	IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u> Hours <u>---</u> Min. <u>---</u>	IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Not known</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A. (?)</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT Address <u>Hospital records - Springfield Hosp.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic neoplastic disease</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary carcinoma of left breast</u> DUE TO (c) <u>---</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs. plus</u> <u>3 yrs. plus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy with mental deficiency</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>---</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>
21. I certify that I attended the deceased from <u>4-30-</u> , 19 <u>30</u> , to <u>4-4-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-4-</u> , 19 <u>56</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. N. Mastin</u> M.D.				ADDRESS (Street, city or town, state) <u>Sykesville Md</u> DATE SIGNED <u>April 4, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Morrell N. Mastin, M.D.</u>				Springfield State Hospital, <u>Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/6/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Acacia Forest</u>		22d. LOCATION (City, town, or county) (State) <u>German Hill Rd</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Fisher &amp; Sons 1318 Light St</u>				24a. REC'D BY REGISTRAR DATE <u>APR 9 1956</u>		24b. REGISTRAR'S SIGNATURE <u>C. Henry Myers</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED

03863

3885

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u> c. LENGTH OF STAY IN lb <u>20 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>C H A R L E S</u> <u>F</u> <u>H A R R I S O N</u> First Middle Last		<b>4. DATE OF DEATH</b> Month <u>April</u> Day <u>7</u> Year <u>1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 29, 1891</u>
<b>9. AGE</b> (In years last birthday) <u>64</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Carb</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>James S. Harrison</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabith Shorts</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Mr. Elmer Harrison - Wife</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>CRUSHING INJURY TO CHEST</u> <u>825X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
<b>20c. TIME OF INJURY</b> <u>6:15 p.m.</u>	<b>20d. INJURY OCCURRED</b> While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Route 32</u>	<b>20f. (City or town) (County) (State)</b> <u>Sykesville Carroll Md.</u>
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u>		<b>DATE SIGNED</b> <u>4/7/56</u>	
<b>EXAMINER'S NAME (Type)</b> <u>JAMES T. MARSH</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, or other Disposal (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>4-10-56</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Jennings Chapel</u>	<b>22d. LOCATION (City, town, or county) (State)</b> <u>Howard Co. Md.</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur H. Haight</u>		<b>24a. REC'D BY REGISTRAR</b> <u>DATE 4-9-56</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Harry</u>			

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate containing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

APR 13 1936

BUREAU V. S.

Handwritten notes and stamps, including "APR 13 1936" and "BUREAU V. S.".

Handwritten notes and stamps, including "APR 13 1936" and "BUREAU V. S.".

Handwritten notes and stamps, including "APR 13 1936" and "BUREAU V. S.".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3887 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03864

Reg. Dist. No. 74

Item 9, Film GL96 4-23-56 et

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>			c. LENGTH OF STAY IN 1b <u>13Y OM 11 D</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1731 E. Pratt Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>ALBERT</u> Middle <u>CHARLES</u> Last <u>HARTMEYER</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/2/03</u>	
9. AGE (In years last birthday) <u>52 50</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>11</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>56</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber's helper</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Albert Hartmeyer</u>				14. MOTHER'S MAIDEN NAME <u>Louise Bunger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Record, Springfield State Hospital</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>  <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic reaction, paranoid type</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Stx</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M. D.</u>				DATE SIGNED <u>4/12/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 13, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY SANDER &amp; SONS, INC.</u> <u>Baltimore Md.</u>				ADDRESS <u>Henry T. Sander</u>			
24a. REC'D BY REGISTRAR <u>APR 16 1956</u>				24b. REGISTRAR'S SIGNATURE <u>C. Harry Deery</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

3897 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
 MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED: [illegible]  
 2. SEX: [illegible]  
 3. AGE: [illegible]  
 4. DATE OF BIRTH: [illegible]  
 5. PLACE OF BIRTH: [illegible]  
 6. OCCUPATION: [illegible]  
 7. CAUSE OF DEATH: [illegible]  
 8. MANNER OF DEATH: [illegible]  
 9. SIGNATURE OF EXAMINER: [illegible]  
 10. DATE OF EXAMINATION: [illegible]

BUREAU V. 2

APR 16 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0386574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6yrs. 8months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>15 Springfield State Hospital</b>				d. STREET ADDRESS <b>2453 Barclay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>FERDINAND</b> Last <b>HECKMAN</b>				4. DATE OF DEATH Month <b>April</b> Day <b>12</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-24-02</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William J. Heckman</b>				14. MOTHER'S MAIDEN NAME <b>Emma Norman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Springfield State Hospital - Sykesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary Thrombosis</b> (c) <b>Pulmonary Edema</b> causes lost.							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>  <b>Minutes</b>  <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with chronic alcoholism, paranoid type.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient was found dead face down in creek.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>4-12</b> p. m. <b>19 56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/12/56</b>	
EXAMINER'S NAME (Type) <b>James T. Marsh</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4-16-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William C. Cook</b>				ADDRESS <b>INC 1317 ST PAULS</b>		24a. REC'D BY REGISTRAR <b>APR 17 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Keays</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		1910		BALTIMORE, MD.	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		PREVIOUS ILLNESS	
Carpenter		High School		Married		Catholic		None		None	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER	
Heart Disease		Natural		Home		April 17, 1956		10:30 AM		J. H. HARRIS	
DETAILS OF CASE		HISTORY		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		POSTMORTEM EXAMINATION		FINDINGS	
Patient was found dead in his home.		No history of illness.		No physical abnormalities.		No laboratory abnormalities.		No postmortem abnormalities.		No findings.	

BUREAU V. S.

APR 17 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3889 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03866

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>			c. LENGTH OF STAY IN 1b <b>1Y 4M 7 D</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		
3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>Leah</b> Last <b>HINES</b>			4. DATE OF DEATH Month <b>4</b> Day <b>25</b> Year <b>19 56</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>5/25/00</b>		9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>25</b> Hours <b>19</b> Min. <b>56</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>USA</b>		
11. BIRTHPLACE (State or foreign country) <b>USA</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>?</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>			16. SOCIAL SECURITY NO. <b>-</b>		
17. INFORMANT <b>Record, Springfield State Hospital</b>			Address <b>Record, Springfield State Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>904.7</b> (b) <b>Coronary artery thrombosis</b> DUE TO (c) <b>Arteriosclerosis of coronary artery</b> INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b> <b>II</b> <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of right hip</b> <b>Chronic brain syndrome assoc. with convulsive disorder with psychosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient fell to floor on ward</b>		
20c. TIME OF INJURY Month, Day, Year Hour <b>4/17</b> a. m. <b>56</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>hospital</b>			20f. (City or town) <b>Sykesville</b> (County) <b>Carroll</b> (State) <b>Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>James T. Marsh</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>James T. Marsh, M. D.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/28/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ST MARYS</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul C. Henowitz</b>		ADDRESS <b>3615-17 Chestnut Ave.</b>		24a. REG'D BY REGISTRAR <b>DATE 2/2/56</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Harris</b>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death	
John Doe		Male		45		1910		New York		123 Main St		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Time of Death		Place of Death		Signature of Examiner	
Teacher		High School		Married		Hypertension		1 week ago		10:00 PM		Home		[Signature]	

Signature of Medical Examiner

Signature of Coroner		Signature of Registrar		Signature of Physician		Signature of Nurse		Signature of Undertaker		Signature of Burial Society		Signature of Cemetery		Signature of Funeral Home	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAY 1 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3890

## CERTIFICATE OF DEATH

03867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>			
c. LENGTH OF STAY IN 1b <u>84 YRS.</u>				d. STREET ADDRESS <u>131 LIBERTY ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>131 LIBERTY ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JACOB THOMAS HOLMES</u>				4. DATE OF DEATH Month Day Year <u>APRIL 5 1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 20 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET. CONTRACTOR+BUILDER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. HOLMES</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. STEVENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-03-5945</u>			
17. INFORMANT <u>(Mrs) RUTH CARBAUGH</u>				Address <u>131 LIBERTY ST. WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremic Coma</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio sclerosis (generalized)</u> DUE TO (c) <u>senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 1</u> , 195 <u>6</u> , to <u>Apr. 5</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>Apr. 5</u> , 195 <u>6</u> , and that death occurred at <u>2:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Westminster, Md. 4-7-56</u> DATE SIGNED <u>C. W. Billingslea</u>							
ACTUAL SIGNATURE <u>C. W. Billingslea</u> M.D.				PHYSICIAN'S NAME (Type) <u>C. W. Billingslea</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4-8-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DEER PARK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>SMALL WOOD MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H BANKARD + Son</u> ADDRESS <u>WESTMINSTER MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

APR 16 1956

BUREAU V. S.

RECEIVED

3860

## CERTIFICATE OF DEATH

Reg. Dist. No. 112

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 16 <u>16 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>174 W. MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WILLIAM</u> Last <u>HULL</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>10</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 25 1875</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CYRUS HULL</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE LEISTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-4193</u>	
17. INFORMANT Address <u>174 W. MAIN</u>		Name <u>CARRIE SMITH HULL WESTMINSTER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Cardio Renal Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>3 mos</u> <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>56</u> to <u>Apr 10</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Apr 9</u> , 19 <u>56</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Johnas. R. Fortz</u> M.D. <u>Westminster Md</u>		DATE SIGNED <u>4-12-56</u>	
PHYSICIAN'S NAME (Type) <u>Johnas. R. Fortz</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-13-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MEADOWBRANCH CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. B. HART</u>		ADDRESS <u>WESTMINSTER MD.</u>	
24a. REC'D BY REGISTRAR <u>4-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

MEDICAL CERTIFICATION

BUREAU V. S.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03869

3891

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>13Y 8 M 23D</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>Formerly of 1905 N. Fulton</b> <b>437 W. Wellington Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. STREET ADDRESS <b>Formerly of 1905 N. Fulton</b> <b>437 W. Wellington Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Veoria</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>4</b> Day <b>30</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/12/73</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>30</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Corwine</b>		14. MOTHER'S MAIDEN NAME <b>--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic nephritis</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic hypertensive cardiovascular disease</b> DUE TO (c) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis with psychosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/28</b> , 19 <b>56</b> , to <b>4/30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/29</b> , 19 <b>56</b> , and that death occurred at <b>4:45 AM DST</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/30/56</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. <b>Sykesville, Maryland</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/2/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickener &amp; Sons - Balto., Md.</b>		24a. REC'D BY REGISTRAR DATE <b>5/2/56</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Keene</b>			

CERTIFICATE OF DEATH

1951

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]	
4. DATE OF DEATH [Illegible]		5. TIME OF DEATH [Illegible]		6. PLACE OF DEATH [Illegible]	
7. CAUSE OF DEATH [Illegible]		8. MANNER OF DEATH [Illegible]		9. SIGNATURE OF PHYSICIAN [Illegible]	
10. SIGNATURE OF REGISTRAR [Illegible]		11. SIGNATURE OF WITNESS [Illegible]		12. SIGNATURE OF DECEASED [Illegible]	
13. SIGNATURE OF DECEASED [Illegible]		14. SIGNATURE OF DECEASED [Illegible]		15. SIGNATURE OF DECEASED [Illegible]	
16. SIGNATURE OF DECEASED [Illegible]		17. SIGNATURE OF DECEASED [Illegible]		18. SIGNATURE OF DECEASED [Illegible]	
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100. SIGNATURE OF DECEASED [Illegible]		101. SIGNATURE OF DECEASED [Illegible]		102. SIGNATURE OF DECEASED [Illegible]	

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MAY 2 1956

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3892

CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Pennsylvania</b> b. COUNTY <b>75X-3</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b>	
c. LENGTH OF STAY IN 1b <b>16 days</b>		d. STREET ADDRESS <b>536 Girard Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>-</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1894</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Eljanow</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma with cerebral metastases</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>3 months plus</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with diseases of unknown or uncertain causes with psych.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>reaction</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-14-</b> , 19 <b>56</b> , to <b>4-28-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-27-</b> , 19 <b>56</b> , and that death occurred at <b>8:25 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Md</b> DATE SIGNED <b>4-28-56</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/2/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>	22d. LOCATION (City, town, or county) (State) <b>Phila. Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Inc. 1217 St Paul Rd Balto.</b>		24a. REC'D BY REGISTRAR <b>DATE 4/28/56</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weber</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES T. JONES		M		38		1897		BALTIMORE		MD		MD		USA	
OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		NAVY SERVICE		ARMY SERVICE		AIR FORCE SERVICE		OTHER SERVICE	
Physician		High School		Married		None		None		None		None		None	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death		Place of Death		City of Death		State of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Home		BALTIMORE		MD	
Date of Death		Time of Death		Place of Death		City of Death		State of Death		Country of Death		Date of Burial		Place of Burial	
1935		10/10		Home		BALTIMORE		MD		USA		1935		BALTIMORE	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier		Signature of Burial Certifier		Signature of Funeral Home		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 31

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03871

3893

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (14)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>4703 Catalpha Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>GEORGE</b> Last <b>KIRCHNER</b>		4. DATE OF DEATH Month <b>April</b> Day <b>13</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 14, 1872</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stationary Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Kirchner</b>		14. MOTHER'S MAIDEN NAME <b>Anna</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Springfield State Hospital - Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS associated with cerebral arteriosclerosis, with psychotic reaction.</b> Chronic Hepatitis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-11</b> , 19 <b>56</b> , to <b>4-13</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-13</b> , 19 <b>56</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>4-13-56</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>4/16, 1956n</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck, 5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>APR 17 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry W...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 5024

THE UNIVERSITY OF CHICAGO PRESS

## CERTIFICATE OF DEATH

Reg. Dist. No.

03872

3894

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> 84 YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BOND ST. EXT.</u>		d. STREET ADDRESS <u>BOND ST. EXT.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LEPOY LEPP</u>		4. DATE OF DEATH Month Day Year <u>APRIL 8 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 2, 1910</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PERCY L. LEPP</u>		14. MOTHER'S MAIDEN NAME <u>ETTA JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-03-5299</u>	
17. INFORMANT <u>SARAH LEPP</u> Address <u>BOND ST. EXT.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Coronary Sclerosis &amp; Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>42 hr</u> <u>(54 months)</u> <u>1954 &amp; 1955</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>54</u> , to <u>April 8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>56</u> , and that death occurred at <u>4:04</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. L. Speicher</u> M.D.		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u> DATE SIGNED <u>4/9/56</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR. 11, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>TRIDERS REF. CEMI.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Bankard</u>		ADDRESS <u>Don Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4-12-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet M. Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3895

## CERTIFICATE OF DEATH

03873

Reg. Dist. No. 76

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		LENGTH OF STAY (in this place) <i>8 y 7 mo</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		TOWN <i>Sykesville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <i>Simon</i> (Middle) (Last) <i>May</i>				<i>4</i> <i>11</i> <i>19 56</i>			
<b>5. SEX</b> <i>male</i>	<b>6. COLOR OR RACE</b> <i>white</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <i>widowed</i>	<b>8. DATE OF BIRTH</b> <i>11-27-1874</i>	<b>9. AGE last birthday</b> <i>81</i> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
					Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Merchant</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Schapo-Iron</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Darmstadt Germany</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>Germany</i>	
<b>13. FATHER'S NAME</b> <i>Hippoman May</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Caroline</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i>		<b>16. SOCIAL SECURITY NO.</b> <i>none</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Daughter Dr. Gerhard Gross, Sykesville Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Generalized arteriosclerosis</i>						<i>years</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>April 1, 19 50</i> , to <i>April 11, 19 56</i> , that I last saw the deceased alive on <i>April 11, 19 56</i> , and that death occurred at <i>11:50p</i> M, from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Walther H. Sonnenfeldt</i>				<b>ADDRESS</b> (Street, city, town, state) <i>Sykesville Md.</i>		<b>DATE SIGNED</b> <i>4/12/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>4-13-56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Rosedale</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Balto Md</i>	
<b>24. REC'D BY REGISTRAR</b> <i>4/13/56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>C. Harry Stokes</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Jack Lewis Inc</i>		<b>ADDRESS</b> <i>2100 Eastow Rd</i>	

PHOTOCOPYING

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# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Form 100-100

1. PLACE OF BIRTH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

BUREAU V. S.

APR 13 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03874

## CERTIFICATE OF DEATH

3896

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Manchester</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ferrier Road</u>		STREET ADDRESS (If rural give location) <u>Ferrier Road</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mrs. (First) Grace E. (Middle) Mc Adow (Last)</u> <u>Mrs. Estella G Mc Adow</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>4/27/ 19 56</u>			
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widowed</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 3, 1877</u>		<b>9. AGE last birthday</b> <u>78</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Adam Snyder</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary ?</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Manchester, Maryland</u> <u>Mrs. Moward Bowling, Ferrier Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>1751</b> IMMEDIATE CAUSE (A) <u>Ovarian Carcinoma</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Hypertension</u>				<u>3 yrs</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Nov 23, 1954</u> to <u>April 27, 1956</u> , that I last saw the deceased alive on <u>April 26, 1956</u> , and that death occurred at <u>10.30 P.M.</u> from the causes and on the date stated above. <u>4/27/56</u>							
<b>SIGNATURE</b> <u>W. H. Ford</u>		<b>M.D.</b> <u>23 North Main St</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Manchester, Md.</u>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>5/1/1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>5/2/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. H. B. Denny</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Leonard J. Ruck, 5305 Marford Road #14</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03875

Reg. Dist. No. 76

3897

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>46 YRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER RD#2</b>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BACHMAN'S VALLEY (SULLIVAN RD.)</b>				d. STREET ADDRESS <b>BACHMAN'S VALLEY</b>			
3. NAME OF DECEASED (Type or print) First <b>ESTHER</b> Middle <b>ELIZABETH</b> Last <b>MILLER</b>				4. DATE OF DEATH Month <b>APRIL</b> Day <b>26</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 26, 1910</b>	9. AGE (In years last birthday) <b>46 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STITCHER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHOE FACTORY</b>		11. BIRTHPLACE (State or foreign country) <b>CARROLL CO., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HOWARD A. BIXLER</b>				14. MOTHER'S MAIDEN NAME <b>ANNA R. MYERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>22-28-3112</b>		17. INFORMANT Address <b>MR. STERLING A. MILLER, WESTMINSTER, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>4/26/56</b>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>APRIL 29 56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MEADOW BRANCH CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>RURAL, WESTMINSTER Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Myers, Jr. Westminster, Md.</b>				ADDRESS <b>4-22-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harold Mally</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, along with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

42 West 11th St. Baltimore, Md.  
 RICHARD ARDREY & SONS, BROS. & CO. - RICHARD ARDREY & SONS, BROS. & CO.

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BUREAU V. 3

208-312 Mr. STEVEN A. MILLER, WESTMINSTER, MD.  
 HOWARD A. BAKER  
 ANNIE K. MILLER  
 STITCHER  
 SHOE FACTORY CARROLL CO. MD. 11-2-56  
 FEB 24/56 46  
 FEMALE WHITE

ESTHER ELIZABETH MILLER  
 APRIL 26 26  
 RICHARD ARDREY & SONS, BROS. & CO.  
 RICHARD ARDREY & SONS, BROS. & CO.  
 CARROLL  
 MARYLAND  
 CARROLL

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER RD</u> c. LENGTH OF STAY IN 1b <u>25 YRS.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, WESTMINSTER RD #7</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLEASANT VALLEY</u>				d. STREET ADDRESS <u>PLEASANT VALLEY</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>J.</u> Middle <u>MILTON</u> Last <u>MILLER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 1, 1902</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR, RUBBER CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CAMBRIDGE</u>		11. BIRTHPLACE (State or foreign country) <u>MILLERS, CARROLL CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN MILLER</u>				14. MOTHER'S MAIDEN NAME <u>CLARA HOFFACKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-9170</u>		17. INFORMANT Address <u>MRS. J. HELWIG MILLER, WESTMINSTER RD #7</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chl. Myocarditis</u> DUE TO <u>several years</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> , to <u>Apr. 14, 1956</u> , that I last saw the deceased alive on <u>Apr. 12, 1956</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hanover, Pa.</u> DATE SIGNED <u>4/15/56</u>							
ACTUAL SIGNATURE <u>Mark Redding</u> M.D.				PHYSICIAN'S NAME (Type) <u>MARK REDDING, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 17, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY CEM. WESTMINSTER, RD #7 Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE 4-14-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2828

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY		16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF		19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JAILER		22. SIGNATURE OF PRISONER		23. SIGNATURE OF GUARD		24. SIGNATURE OF WARDEN		25. SIGNATURE OF CHIEF OF POLICE		26. SIGNATURE OF DETECTIVE		27. SIGNATURE OF OFFICER		28. SIGNATURE OF SERGEANT		29. SIGNATURE OF CAPTAIN		30. SIGNATURE OF MAJOR		31. SIGNATURE OF LIEUTENANT		32. SIGNATURE OF PRIVATE		33. SIGNATURE OF SQUAD LEADER		34. SIGNATURE OF PLATOON LEADER		35. SIGNATURE OF COMPANY COMMANDER		36. SIGNATURE OF BATTALION COMMANDER		37. SIGNATURE OF REGIMENT COMMANDER		38. SIGNATURE OF BRIGADE COMMANDER		39. SIGNATURE OF DIVISION COMMANDER		40. SIGNATURE OF CORPS COMMANDER		41. SIGNATURE OF ARMY COMMANDER		42. SIGNATURE OF NAVY COMMANDER		43. SIGNATURE OF AIR FORCE COMMANDER		44. SIGNATURE OF MARINE COMMANDER		45. SIGNATURE OF COAST GUARD		46. SIGNATURE OF CUSTOMS		47. SIGNATURE OF REVENUE		48. SIGNATURE OF POST OFFICE		49. SIGNATURE OF RAILROAD		50. SIGNATURE OF STEAMSHIP		51. SIGNATURE OF AIRCRAFT		52. SIGNATURE OF MOTOR VEHICLE		53. SIGNATURE OF FERRY		54. SIGNATURE OF TUGBOAT		55. SIGNATURE OF SLOOP		56. SIGNATURE OF YACHT		57. SIGNATURE OF BOAT		58. SIGNATURE OF CANOE		59. SIGNATURE OF SKIFF		60. SIGNATURE OF ROWBOAT		61. SIGNATURE OF SLED		62. SIGNATURE OF ICEBERG		63. SIGNATURE OF SHIPWRECK		64. SIGNATURE OF DISASTER		65. SIGNATURE OF ACCIDENT		66. SIGNATURE OF SUICIDE		67. SIGNATURE OF MURDER		68. SIGNATURE OF ROBBERY		69. SIGNATURE OF BURGLARY		70. SIGNATURE OF THEFT		71. SIGNATURE OF VANDALISM		72. SIGNATURE OF ARSON		73. SIGNATURE OF TERRORISM		74. SIGNATURE OF RIOT		75. SIGNATURE OF STRIKE		76. SIGNATURE OF LOCKOUT		77. SIGNATURE OF GOVERNMENT		78. SIGNATURE OF PRIVATE		79. SIGNATURE OF INDIVIDUAL		80. SIGNATURE OF CORPORATION		81. SIGNATURE OF PARTNERSHIP		82. SIGNATURE OF TRUST		83. SIGNATURE OF ESTATE		84. SIGNATURE OF PROBATE		85. SIGNATURE OF WILLS		86. SIGNATURE OF INTESTATE		87. SIGNATURE OF TESTATE		88. SIGNATURE OF LEGAL		89. SIGNATURE OF JUDICIAL		90. SIGNATURE OF LEGISLATIVE		91. SIGNATURE OF EXECUTIVE		92. SIGNATURE OF JUDICIAL		93. SIGNATURE OF LEGISLATIVE		94. SIGNATURE OF EXECUTIVE		95. SIGNATURE OF JUDICIAL		96. SIGNATURE OF LEGISLATIVE		97. SIGNATURE OF EXECUTIVE		98. SIGNATURE OF JUDICIAL		99. SIGNATURE OF LEGISLATIVE		100. SIGNATURE OF EXECUTIVE	
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BUREAU V. S.

APR 17 1956

RECEIVED

3899

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Finksburg</b>			
c. LENGTH OF STAY IN 1b <b>life</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R 1 Sandymount</b>				d. STREET ADDRESS <b>R 1 Sandymount</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Bonnie</b> First <b>Carol</b> Middle <b>Monath</b> Last				4. DATE OF DEATH Month <b>April</b> Day <b>21</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 26, 1955</b>	
				9. AGE (In years lost birthday) yrs. <b>4</b> Months <b>25</b> Days <b></b> Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b></b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>			
				11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			
				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Howard J. Monath</b>				14. MOTHER'S MAIDEN NAME <b>Alma C. Tipton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Howard J. Monath</b> Address <b>R 1 Finksburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>4-19-1956</b> , to <b>4-21-1956</b> , that I last saw the deceased alive on <b>4-21-1956</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. C. Jennette</b> M.D. <b>Westminster Md</b>				DATE SIGNED <b>4-21-56</b>			
PHYSICIAN'S NAME (Type) <b>W. C. Jennette 103 E. Main St. Westminster, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 22, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sandymount</b>		22d. LOCATION (City, town, or county) (State) <b>Sandymount, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b> ADDRESS <b>Westminster, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 4-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>Harold Miller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

248181437

RECEIVED

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

# 1 3900 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

03878

Reg. Dist. No. 71

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNIONTOWN RURAL</u>	
c. LENGTH OF STAY IN lb <u>3 WEEKS</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	

3. NAME OF DECEASED (Type or print) <u>FRANKLIN EUGENE MORT JR</u>		4. DATE OF DEATH <u>APRIL 9 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 19-1956</u>
9. AGE (In years lost birthday) <u>3 WEEKS</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			

13. FATHER'S NAME <u>FRANKLIN E MORT</u>		14. MOTHER'S MAIDEN NAME <u>MABEL MYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANKLIN E MORT</u>		Address <u>UNIONTOWN RURAL MD</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>751X Meningitis</u> DUE TO (b) <u>Spina Bifida - Meningocele</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>21 days</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>Apr 7</u> , 19 <u>56</u> , to <u>Apr 9</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Apr 9</u> , 19 <u>56</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>James J. Marsh</u> M.D.	DATE SIGNED <u>MD 4/9/56</u>
PHYSICIAN'S NAME (Type) <u>JAMES J MARSH</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>APRIL 11-1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>	22d. LOCATION (City, town, or county) (State) <u>UNIONTOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>B.D. Hartley &amp; Sons New Windsor Md</u>		24a. REC'D BY REGISTRAR <u>DATE 4/11/56</u>	24b. REGISTRAR'S SIGNATURE <u>Margaret R. Englar</u>

2069201405

# CERTIFICATE OF DEATH

STATE OF ARIZONA DEPARTMENT OF HEALTH - BUREAU OF VITALS

NAME OF DECEASED		DATE OF BIRTH	
SEX		RACE	
MARRIED		OCCUPATION	
EDUCATION		RELIGION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
DATE OF REGISTRATION		PLACE OF REGISTRATION	

BUREAU V. S.

APR 24 1956

RECEIVED

## CERTIFICATE OF DEATH

03879

Reg. Dist. No. #78

3971

<b>1. PLACE OF DEATH</b> o. COUNTY <u>CARROLL</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>Carroll</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAYLORSVILLE</u>			c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near- Taylorsville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>RFD # 5, Westminster</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JESSE</u> Middle <u>KESTER</u> <u>Myers</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>23 Oct</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>CARROLL MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Cleveland MUERS</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE STEM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 34 5852</u>		17. INFORMANT <u>ANGIE MYERS</u> <span style="float: right;">Address <u>Westminster</u></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 Oct 56</u> <u>to April 56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 March, 1956</u> , to <u>2 April, 1956</u> , that I last saw the deceased alive on <u>2 April 56</u> , 19____, and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall MD</u>				ADDRESS (Street, city or town, state) <u>SYKESVILLE, MD</u>		DATE SIGNED <u>2 April 56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				<u>SYKESVILLE, MD</u>		<u>2 April 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Apr 4-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pipe Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Near UNIONTOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>RAYMOND K. WRIGHT</u>				ADDRESS <u>Union Bridge MD</u>		24a. REC'D BY REGISTRAR <u>4/4/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Paula R. Reppe</u> <u>May 2 1956</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, or the hospital or attending physician. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, or the hospital or attending physician. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, or the hospital or attending physician.

CERTIFICATE OF DEATH

3201

NAME OF DECEASED <i>KESTER, JAMES</i>		SEX <i>M</i>		AGE <i>32</i>	
DATE OF BIRTH <i>1923</i>		PLACE OF BIRTH <i>MD</i>		RACE <i>W</i>	
OCCUPATION <i>None</i>		EDUCATION <i>None</i>		RELIGION <i>None</i>	
MARITAL STATUS <i>Single</i>		DATE OF MARRIAGE <i>None</i>		NAME OF SPOUSE <i>None</i>	
DATE OF DEATH <i>1955</i>		PLACE OF DEATH <i>MD</i>		CAUSE OF DEATH <i>None</i>	
MANNER OF DEATH <i>None</i>		CERTIFICATE NO. <i>3201</i>		REGISTERED <i>None</i>	

BUREAU V. S.

APR 5 1955

RECEIVED

3922

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PLEASANT VALLEY</u>				d. STREET ADDRESS <u>PLEASANT VALLEY</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LEROY EDWARD MYERS</u>				4. DATE OF DEATH Month Day Year <u>APRIL 3 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 5, 1918</u>	9. AGE (In years last birthday) <u>38</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>T.V. and Appliance Repair Pleasant Valley, Carroll Co., Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. Leroy Myers</u>				14. MOTHER'S MAIDEN NAME <u>Laura Heuman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-1408</u>		17. INFORMANT Address <u>MRS. LEROY E. MYERS, WESTMINSTER, MD, RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>                    </u> DUE TO <u>                    </u> (c) <u>                    </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>May, 1945</u> , to <u>Apr 3, 1956</u> , that I last saw the deceased alive on <u>Apr 2, 1956</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.C. Jenette</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>W.C. JENNETTE</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 6 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT VALLEY CEM. RURAL WESTMINSTER, MD</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.S. Myers Jr - Westminster, Md</u>				ADDRESS <u>                    </u>		24a. REC'D BY REGISTRAR DATE <u>4-6-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 9 1956

RECEIVED

3903

## CERTIFICATE OF DEATH

0388174  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 M 7 D</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3701-46 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>19 W. 27th Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>George</b>		Middle <b>NIELSON</b>		Last <b>16 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/14/87</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>steel</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk.</b>		16. SOCIAL SECURITY NO. <b>213-09-2423</b>	
17. INFORMANT <b>Record, Springfield State Hospital</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia with multiple lung abscesses</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b> <b>2-3 months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Brain Syndrome assoc. with cerebral arteriosclerosis, with psychosis</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>2/10</b> , 19 <b>56</b> , to <b>4/16</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/15</b> , 19 <b>56</b> , and that death occurred at <b>7:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/16/56</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Sykesville, Maryland</b>		DATE SIGNED <b>4/16/56</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/19/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimmek Funeral Home, Inc.</b>				ADDRESS <b>2601 E. Madison St.</b>		24a. REC'D BY REGISTRAR <b>APR 19 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

APR 19 1956

RECEIVED  
APR 19 1956

3905

CERTIFICATE OF DEATH

03883

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Garrett Alleg.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaVale (Cumberland)</b>				d. STREET ADDRESS <b>01X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Simon</b> Middle <b>J.</b> Last <b>Orendorf</b>				4. DATE OF DEATH Month <b>April</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/21/78</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>		IF UNDER 24 HRS. Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Joel Orendorf</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Bitteringer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>42-576078</b>			
17. INFORMANT <b>Springfield Hospital records, Sykesville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarction of myocardium anterior &amp; lateral wall</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>—</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>days</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour <b>—</b> a. m. <b>—</b> p. m. <b>19</b> 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4/17/56</b> , 19 <b>—</b> to <b>4/20/56</b> , 19 <b>—</b> , that I last saw the deceased alive on <b>4/20/56</b> , 19 <b>—</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland.</b> DATE SIGNED <b>4/20/56</b> ACTUAL SIGNATURE <b>Edmund L. Lushau</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund L. Lushau</b> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/23/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FOLK</b>		22d. LOCATION (City, town, or county) (State) <b>RURAL GRANTSVILLE GARRETT Co MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald J. Newman</b>				24a. REC'D BY REGISTRAR <b>4-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Willis</b>	

CERTIFICATE OF DEATH

8002

NAME OF DECEASED <b>John Doe</b>		DATE OF BIRTH <b>1900</b>		PLACE OF BIRTH <b>Maryland</b>	
SEX <b>Male</b>		RACE <b>White</b>		EDUCATION <b>High School</b>	
OCCUPATION <b>Farmer</b>		MARRIAGE <b>Married</b>		DATE OF MARRIAGE <b>1920</b>	
PLACE OF DEATH <b>Home</b>		DATE OF DEATH <b>1950</b>		CAUSE OF DEATH <b>Heart Disease</b>	
MANNER OF DEATH <b>Natural</b>		CERTIFICATE NO. <b>8002</b>		REGISTERED <b>Yes</b>	
DATE OF REGISTRATION <b>1950</b>		PLACE OF REGISTRATION <b>State</b>		OFFICIAL SIGNATURE <b>[Signature]</b>	
DATE OF DEATH <b>1950</b>		PLACE OF DEATH <b>Home</b>		CAUSE OF DEATH <b>Heart Disease</b>	
MANNER OF DEATH <b>Natural</b>		CERTIFICATE NO. <b>8002</b>		REGISTERED <b>Yes</b>	
DATE OF REGISTRATION <b>1950</b>		PLACE OF REGISTRATION <b>State</b>		OFFICIAL SIGNATURE <b>[Signature]</b>	

BUREAU V. S.

APR 24 1950

RECEIVED

3904

CERTIFICATE OF DEATH

03882

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr. 9days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		4. DATE OF DEATH Month <b>April</b>		Day <b>7</b>		Year <b>1956</b>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b>		Middle <b>ALFRED</b>		Last <b>PARE</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>10-1-87</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b>		IF UNDER 24 HRS. Days <b>7</b>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk -</b>		11. BIRTHPLACE (State or foreign country) <b>Vermont</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph L. Pare</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Pare</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1906 to 1910</b>		17. INFORMANT <b>Unk -</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X Carcinoma of the lung w. metastases</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>1yr +</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome assoc. with intoxication, alcohol intoxication, without qualifying phrase, plus cerebral arteriosclerosis.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield State Hospital</b>		(County) <b>Sykesville</b>		(State) <b>Md.</b>		21. I certify that I attended the deceased from <b>3-28</b> , 19 <b>55</b> , to <b>4-7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4-7</b> , 19 <b>56</b> , and that death occurred at <b>10:15A</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
21. ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		DATE SIGNED <b>4-7-56</b>		PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt</b>		22. DATE THEREOF <b>4-12-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>	
22d. LOCATION (City, town, or county) <b>Sykesville, Maryland</b>		22e. LOCATION (City, town, or county) <b>Sykesville, Md.</b>		22f. LOCATION (City, town, or county) <b>Sykesville, Md.</b>		22g. LOCATION (City, town, or county) <b>Sykesville, Md.</b>		22h. LOCATION (City, town, or county) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR <b>4-12-56</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Ecker</b>			

—

**W. L. EAV**

APR 17 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3906 CERTIFICATE OF DEATH

03884

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural--Sykesville</b>		LENGTH OF STAY (in this place) <b>11 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural--Sykesville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Eldersburg</b>				STREET ADDRESS (If rural give location) <b>Eldersburg</b>			
3. NAME OF DECEASED (Type or Print) <b>SHRIVER E. PICKETT</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>April 7, 19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <b>married</b>	8. DATE OF BIRTH <b>10-8-1887</b>		9. AGE last birthday <b>68</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John W. Pickett</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Jane Penn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT & ADDRESS <b>Mrs. Fannie E. Pickett, Same</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.0 IMMEDIATE CAUSE (A) <b>Cardiac Arrest</b>						<b>Several years</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic heart disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Hypertension - C.V.A.</b>						<b>7 April 56</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7 April, 19 56</b> , to <b>7 April, 19 56</b> , that I last saw the deceased alive on <b>7 April, 19 56</b> , and that death occurred at <b>11:01 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>Howard E. Hall</b>				M. D. <b>Agnewville, Md</b>		DATE SIGNED <b>8 April 56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		DATE THEREOF <b>4-10-1956</b>		NAME OF CEMETERY OR CREMATORY <b>Ebenezer</b>		LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
24. REC'D BY REGISTRAR <b>H-10-56</b>		REGISTRAR'S SIGNATURE <b>C. Harry Tucker</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz,</b>		ADDRESS <b>Winfield, Md.</b>	

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence of Deceased

John W. Blakeslee

John W. Blakeslee

John W. Blakeslee

John W. Blakeslee

John W. Blakeslee

John W. Blakeslee

John W. Blakeslee

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John W. Blakeslee

John W. Blakeslee

BUREAU V. 2

APR 13 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3977

## CERTIFICATE OF DEATH

0388574

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 M, 18 D</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>2810 Rosalie Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>John H. RENNER</b>				4. DATE OF DEATH Month <b>4</b> Day <b>12</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/5/80</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Druggist</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Renner</b>			
14. MOTHER'S MAIDEN NAME <b>Mollie HELDOEFER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>none</b>				17. INFORMANT Address <b>Record, Springfield State Hospital, Sykesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>days</b>  <b>days</b>  <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Sykesville</b>				20g. (County) <b>Carroll</b>		20h. (State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>2/26</b> 19 <b>56</b> , to <b>4/12</b> 19 <b>56</b> , that I last saw the deceased alive on <b>4/12</b> 19 <b>56</b> , and that death occurred at <b>9 PM</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/12/56</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				M.D. <b>Sykesville, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 16. 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b> <b>Baltimore Md.</b>				ADDRESS <b>Seagraves &amp; Sons</b>		24a. REC'D BY REGISTRAR DATE <b>4/17/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Weir</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. DATE OF MARRIAGE [REDACTED]	
9. DATE OF DEATH [REDACTED]		10. TIME OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. CAUSE OF DEATH [REDACTED]	
13. MEDICAL HISTORY [REDACTED]		14. PRESENT ILLNESS [REDACTED]		15. TREATMENT [REDACTED]		16. PHYSICIAN'S SIGNATURE [REDACTED]	
17. CORONER'S SIGNATURE [REDACTED]		18. COUNTY CLERK'S SIGNATURE [REDACTED]		19. DATE [REDACTED]		20. TIME [REDACTED]	

BUREAU V. 8

APR 17 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3908

### CERTIFICATE OF DEATH

03886

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>2Y 1M 9D</u>				d. STREET ADDRESS <u>517 S. Register Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>BALBINA</u> Middle <u>Barbara</u> Last <u>SKRUCHA</u>				<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>25</u> Year <u>19 56</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10/22/00</u>	
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>laborer Langral</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>packing houses</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Polish Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Edward Skrucha</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Anna Pipczynski</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-07-9013</u>		<b>17. INFORMANT</b> <u>Record, Springfield State Hospital</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Involuntional psychotic reaction</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>a. p.</u> <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <u>3/17</u> , 19 <u>56</u> , to <u>4/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>56</u> , and that death occurred at <u>1:22 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sykesville, Maryland</u> DATE SIGNED <u>4/25/56</u>							
<b>ACTUAL SIGNATURE</b> <u>Walther H. Sonnenfeldt</u> M.D.				<b>PHYSICIAN'S NAME</b> (Type) <u>Walther H. Sonnenfeldt, M. D.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>4/28/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Stanislaus Cem.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore City</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Weber</u>				<b>ADDRESS</b> <u>401 S. Chester Street</u>			
<b>24a. REC'D. BY REGISTRAR</b> <u>APR 27 1956</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>C. Harry</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R 6 Smallwood</b>				d. STREET ADDRESS <b>R 6 Smallwood</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Franklin</b> Last <b>Sr. Spencer</b>				4. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 8, 1882</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>William Ernest Spencer</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Lockard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT Address <b>Ralph H. Spencer R 6 Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation - Caused by fire</b> DUE TO <b>in trailer while deceased</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>was asleep -</b> DUE TO <b>was asleep -</b> (c) <b>was asleep -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Carroll</b>	
21. I certify that I attended the deceased from <b>4/28</b> , 19 <b>56</b> , to <b>4/28</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/28</b> , 19 <b>56</b> , and that death occurred at <b>10 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Luther Bare</b>		M.D. <b>Deputy Medical Examiner</b>		ADDRESS (Street, city or town, state) <b>Westminster Maryland</b>		DATE SIGNED <b>5-1-56</b>	
PHYSICIAN'S NAME (Type) <b>S. Luther Bare</b>		<b>79 W. Main St.</b>		<b>Westminster Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 1, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Gamber, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers Westminster, Maryland</b>				24a. REC'D BY REGISTRAR <b>5-1-56</b>		24b. REGISTRAR'S SIGNATURE <b>H. M. M. M.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
John R. Evans		May 1, 1956	
Age		Date of Birth	
65		April 1, 1891	
Sex		Race	
Male		White	
Married		Usual Residence	
Yes		Baltimore, Md.	
Cause of Death		Place of Death	
Heart Failure		Home	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Coronary Atherosclerosis	
Duration of Illness		Date of Admission to Hospital	
10 days		April 15, 1956	
Name of Physician		Name of Hospital	
Dr. J. H. Jones		St. Mary's Hospital	
Signature of Physician		Signature of Registrar	
[Signature]		[Signature]	

BUREAU V. 2

MAY 3 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3910

## CERTIFICATE OF DEATH

03888

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4 mos. 9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>803 Easley Street</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>WILSON</b> Last <b>STABLER</b>				4. DATE OF DEATH Month <b>4</b> Day <b>3</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/14/00</b>	9. AGE (In years last birthday) <b>55</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Budget official</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Montgomery County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Tarlton B. Stabler</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Moore</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>YES</b>		17. INFORMANT <b>Record, Springfield State Hospital, Sykesville</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of coronary arteries with acute in-</b> <b>420.1</b> DUE TO <b>farction of the left ventricle wall</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Degenerating pulmonary infarction</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>years</b> <b>Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/20</b> , 19 <b>56</b> , to <b>4/3</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/3</b> , 19 <b>56</b> , and that death occurred at <b>12:45 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/3/56</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/5/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FRIENDS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>4-5-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. Harry Wilson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3410

NAME OF DECEASED JAMES E. SMITH		DATE OF DEATH APR 9 1956	
AGE 45		SEX M	
RACE W		EDUCATION H	
OCCUPATION Carpenter		MANNER OF DEATH Natural	
PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease	
MEDICAL HISTORY Hypertension, Diabetes		TREATMENT Medical	
DATE OF BIRTH APR 15 1911		PLACE OF BIRTH Baltimore, Md.	
FATHER'S NAME John E. Smith		MOTHER'S NAME Mary E. Smith	
FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF BIRTH JAN 1 1885		MOTHER'S DATE OF BIRTH JUN 15 1890	
FATHER'S PLACE OF BIRTH Maryland		MOTHER'S PLACE OF BIRTH Maryland	
FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF DEATH N/A		MOTHER'S DATE OF DEATH N/A	
FATHER'S PLACE OF DEATH N/A		MOTHER'S PLACE OF DEATH N/A	
FATHER'S CAUSE OF DEATH N/A		MOTHER'S CAUSE OF DEATH N/A	
FATHER'S MEDICAL HISTORY N/A		MOTHER'S MEDICAL HISTORY N/A	
FATHER'S TREATMENT N/A		MOTHER'S TREATMENT N/A	
FATHER'S DATE OF BIRTH JAN 1 1885		MOTHER'S DATE OF BIRTH JUN 15 1890	
FATHER'S PLACE OF BIRTH Maryland		MOTHER'S PLACE OF BIRTH Maryland	
FATHER'S OCCUPATION Carpenter		MOTHER'S OCCUPATION Homemaker	
FATHER'S DATE OF DEATH N/A		MOTHER'S DATE OF DEATH N/A	
FATHER'S PLACE OF DEATH N/A		MOTHER'S PLACE OF DEATH N/A	
FATHER'S CAUSE OF DEATH N/A		MOTHER'S CAUSE OF DEATH N/A	
FATHER'S MEDICAL HISTORY N/A		MOTHER'S MEDICAL HISTORY N/A	
FATHER'S TREATMENT N/A		MOTHER'S TREATMENT N/A	

BUREAU V. S.

APR 9 1956

RECEIVED

3911

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Westminster</u>				c. LENGTH OF STAY IN 1b <u>50 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE EMANUEL STONER</u>				4. DATE OF DEATH Month Day Year <u>APRIL 30 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB 3 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>murderman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>grower</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Emmanuel Stoner</u>				14. MOTHER'S MAIDEN NAME <u>Maria Royer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mrs. Jesse E. Stoner, Westminster Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Pneumonia (Probable Virus)</u> DUE TO (b) <u>arteriosclerotic Cardio</u> DUE TO (c) <u>Renal disease (Severe)</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April 16, 1956</u> to <u>April 30, 1956</u> , that I last saw the deceased alive on <u>April 15, 1956</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. G. Lewis</u>				ADDRESS (Street, city or town, state) <u>Westminster Md</u>			
DATE SIGNED <u>4/30/56</u>							
PHYSICIAN'S NAME (Type) <u>W. G. Lewis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>May 3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cemetery Westminster Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Moore, Jr.</u>		ADDRESS <u>Westminster Md</u>		24a. REC'D BY REGISTRAR <u>5-1-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harold Miller</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

3861

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>20 YRS</u>		d. STREET ADDRESS <u>77 COLONIAL AVE.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>77 COLONIAL AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>THELMA BLANCHE STONER</u>		4. DATE OF DEATH Month Day Year <u>4-28 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 14-1908</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES HUGHES</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE J. SHETTL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>J. ALBERT STONER</u>		Address <u>77 COLONIAL AVE. WESTMINSTER, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>3 Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 Lungs</u> DUE TO (c) <u>2 Lungs</u>		INTERVAL BETWEEN ONSET AND DEATH (1) <u>4 yrs</u> (2) <u>2 yrs</u> (3) <u>2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>174X</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2-16-1956</u> to <u>4-28-1956</u> , that I last saw the deceased alive on <u>4-27-1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.C. Jeannotte</u> M.D.		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md 21151-57</u>	
PHYSICIAN'S NAME (Type) <u>Wm Carl Jeannotte MD</u>		DATE SIGNED <u>5-1-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAY 2, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HANDMOUNT CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H BANNARD SON</u>		ADDRESS <u>WESTMINSTER MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Penley</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3912

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>4 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hampstead</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				d. STREET ADDRESS <i>R. D. # 2.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Shant</i> Last <i>Strevig</i>				4. DATE OF DEATH Month <i>4</i> Day <i>4</i> Year <i>1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-3-1865</i>	
9. AGE (In years last birthday) <i>90</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Ephraim Strevig</i>				14. MOTHER'S MAIDEN NAME <i>Erene Fowble</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Hospital records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>2 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>O. B. S. due to Disturbance of Metabolism without periodic</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3-8-</i> 19 <i>56</i> , to <i>4-4-</i> 19 <i>56</i> , that I last saw the deceased alive on <i>4-4-</i> 19 <i>56</i> , and that death occurred at <i>11:35 P. M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i> M.D.				ADDRESS (Street, city, or town, state) <i>Springfield State Hospital</i>			
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>				DATE SIGNED <i>4/4/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4-7-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Grave Run</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw C. Tipton</i>				ADDRESS <i>Hampstead</i>		24a. REC'D BY REGISTRAR DATE <i>4-5-56</i>	
				24b. REGISTRAR'S SIGNATURE <i>C. Harry Myers</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1985

REC'D

Handwritten notes at the bottom of the page:

Handwritten:  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

Printed:  $\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

3913

CERTIFICATE OF DEATH

03893

Reg. Dist. No. 81

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>				d. STREET ADDRESS <u>RURAL</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY E STUFFLE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 25 19 56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/24/1894</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>J. THADDEUS STARR</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA CROUSE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>189-09-1984</u>		17. INFORMANT Address <u>J. H. STUFFLE, UNION BRIDGE, RURAL MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralysis of throat</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Apr 1, 1956</u> to <u>Apr 23, 1956</u> that I last saw the deceased alive on <u>Apr 24, 1956</u> and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. MESSLER</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge, Md.</u> DATE SIGNED <u>Apr 25, 1956</u>			
PHYSICIAN'S NAME (Type) <u>J. H. MESSLER MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HANOVER, PENNA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartzler &amp; Sons, Union Bridge, Md.</u> ADDRESS _____				24a. REC'D BY REGISTRAR <u>Ledie L. Reppe</u> DATE <u>4/27/56</u>		24b. REGISTRAR'S SIGNATURE _____	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

RECEIVED  
APR 30 1955

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3914

## CERTIFICATE OF DEATH

03894

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Rural - Sykesville</u>		<u>since 4/5/47</u>		TOWN <u>Westminster</u>		27	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>21 Park Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Cornelius Sleight TARKINGTON</u>				<u>April 19 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>male</u>	<u>white</u>	<u>married</u>	<u>March 25, 1883</u>	<u>73</u> yrs.	Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Carpenter</u>		<u>Carpentry</u>		<u>Washington Co., North Carolina</u>		<u>United States</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Samuel Tarkington</u>				<u>Anna Ritchey</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>465X Gangrene of the lungs with abscess formation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Thrombosis of pulmonary artery</u>						<u>days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>Schizophrenic reaction, paranoid type</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>—</u>		<u>—</u>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<u>—</u>		<u>—</u>		<u>—</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>—</u>		<u>M. —</u>		<u>—</u>			
<b>22. I hereby certify</b> that I attended the deceased from <u>March 23, 1948, to April 19, 1956</u> , that I last saw the deceased alive on <u>April 19, 1956</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<u>Martin Cross, M.D.</u>		<u>Sykesville, Maryland</u>		<u>4-20-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> (State)	
<u>Burial</u>		<u>April 23/56</u>		<u>Meadow Branch</u>		<u>Rural, Westminster</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>—</u>		<u>C. Harry Wilson</u>		<u>J. S. Meyer Jr.</u>		<u>Westminster, Md.</u>	
<b>DATE</b>		<u>4-21-56</u>		<u>—</u>			

210177-1714

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 01-11-2001 BY 60322 UCBAW/SJS

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1956

DECEASED

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 01-11-2001 BY 60322 UCBAW/SJS

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. 2

APR 24 1956

RECEIVED

3915

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Mexico</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Mexico</b>		
c. LENGTH OF STAY IN 1b <b>Life</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster R 4</b>			d. STREET ADDRESS <b>Westminster R 4</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Catherine Arbula Tawney</b>			4. DATE OF DEATH <b>April 2 19 56</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1887</b>		9. AGE (In years last birthday) <b>69</b> yrs.
			IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Fred C. Feiese</b>			14. MOTHER'S MAIDEN NAME <b>Ida Long</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>		17. INFORMANT <b>Gilbert T. Friese</b> Address <b>Braddock Heights, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Haemorrhage</b> DUE TO <b>Acute Nephritis following Acute Tonsillitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>8 days</b> (c) <b>5 -</b>					INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>March 25, 1956</b> to <b>April 2, 1956</b> , that I last saw the deceased alive on <b>April 2, 1956</b> , and that death occurred at <b>3 P. M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>S. Luther Bare</b>		ADDRESS (Street, city or town, state) <b>Westminster Maryland</b> DATE SIGNED <b>4/5/56</b>			
PHYSICIAN'S NAME (Type) <b>S. Luther Bare</b>		<b>79 W. Main St. Westminster, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Apr. 5, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Leister's</b>	
		22d. LOCATION (City, town, or county) <b>near Westminster, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>		24a. REC'D BY REGISTRAR <b>4-5-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>H. O. Muller</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

03896 76

Reg. Dist. No. 33

|  |                               |  |                                      |  |                 |   |  |
|--|-------------------------------|--|--------------------------------------|--|-----------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Carroll</u> MARYLAND   |                               |  |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> |                 |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Embury</u>   |                               |  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Embury Md.</u>   |                 |   |  |
| c. LENGTH OF STAY IN 1b <u>57 yrs.</u>   |                               |  |                                      | d. STREET ADDRESS <u>Sandysprout</u>   |                 |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sandysprout</u>  |                               |  |                                      | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                 |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Charlotte M. Voot</u>   |                               |  |                                      | 4. DATE OF DEATH <u>April 5 1956</u>   |                 |   |  |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 12, 1883</u> | 9. AGE (In years last birthday) <u>72</u> yrs.   | IF UNDER 1 YEAR | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               |  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>   |                 | 11. BIRTHPLACE (State or foreign country) <u>Washington D.C.?</u>               |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                               |  |                                      |  |                 |   |  |
| 13. FATHER'S NAME <u>August Giesecke</u>   |                               |  |                                      | 14. MOTHER'S MAIDEN NAME <u>Lena Seebold</u>   |                 |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>   |                               |  |                                      | 16. SOCIAL SECURITY NO. <u>—</u>   |                 |   |  |
| 17. INFORMANT <u>Frank L. Voot Jr. Embury Md.</u>  |                               |  |                                      | Address <u>—</u>   |                 |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u><br><u>420.1</u> DUE TO <u>Hypertension + arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocarditis chronic decompensated</u><br>DUE TO (c) <u>1 yr</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>—</u> |                               |  |                                      |  |                 |   |  |
| INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>   |                               |  |                                      |  |                 |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |  |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                 |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. <u>11</u> p. m. 19 <u>56</u>   |                               |  |                                      | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> |                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> |  |
| 20f. (City or town) <u>Reisterstown Md.</u>  |                               |  |                                      | 20g. (County) <u>—</u>   |                 | 20h. (State) <u>—</u>   |  |
| 21. I certify that I attended the deceased from <u>1-1-46</u> 19 <u>46</u> to <u>4-5-56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>2-10-56</u> 19 <u>56</u> and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above.   |                               |  |                                      |  |                 |   |  |
| ACTUAL SIGNATURE <u>James S. Saffell</u> M.D.  |                               |  |                                      | DATE SIGNED <u>4-5-56</u>  |                 |   |  |
| PHYSICIAN'S NAME (Type) <u>James Saffell</u>   |                               |  |                                      | ADDRESS (Street, city or town, state) <u>Reisterstown Md.</u>  |                 |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried April 7, 56 Druid Ridge Cemetery Pikesville, Balt. Co. Md.</u>   |                               | 22b. DATE THEREOF <u>April 7, 56</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>   |                 | 22d. LOCATION (City, town, or county) (State) <u>Pikesville, Balt. Co. Md.</u>  |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr., Westminster Md.</u>   |                               |  |                                      | 24a. RECEIVED BY REGISTRAR <u>—</u>  |                 | 24b. REGISTRAR'S SIGNATURE <u>Harold Elmer</u>                                  |  |
|  |                               |  |                                      | DATE <u>4-6-56</u>   |                 |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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John Smith

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03897

3917

## CERTIFICATE OF DEATH

Reg. Dist. No. 26

|  |                              |  |                                     |   |   |  |  |
|--|------------------------------|--|-------------------------------------|---|---|--|--|
| <b>1. PLACE OF DEATH</b>   |                              |  |                                     | <b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>  |   |  |  |
| COUNTY <u>CARROLL</u>  |                              | MARYLAND   |                                     | STATE <u>MD.</u>  |   | COUNTY <u>CARROLL</u>  |  |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>R.D. 1 NEW WINDSOR</u>  |                              | LENGTH OF STAY (in this place)<br><u>75 YRS</u>                        |                                     | CITY (If outside corporate limits, write RURAL and give nearest town)<br>TOWN <u>R.D. 1 NEW WINDSOR</u> |   |  |  |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS<br><u>11111</u>  |                              |  |                                     | STREET ADDRESS (If rural give location)<br><u>1</u>   |   |  |  |
| <b>3. NAME OF DECEASED</b><br>(Type or Print) <u>MINNIE CATHERINE WARNER</u>   |                              |  |                                     | <b>4. DATE OF DEATH</b><br>(Month) (Day) (Year)<br><u>APRIL 10 1956</u>                                 |   |  |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)<br><u>WIDOW</u>       | 8. DATE OF BIRTH<br><u>2-4-1881</u> | 9. AGE last birthday<br><u>75</u> yrs.  | IF UNDER 1 YEAR<br>Months Days                            |  | IF UNDER 24 HRS.<br>Hours Min.               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><u>U.S.A</u> |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u> |
| 13. FATHER'S NAME<br><u>WM. MCLELLAN</u>   |                              |  |                                     | 14. MOTHER'S MAIDEN NAME<br><u>GUSTA STRINE</u>   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)<br><u>NO</u>   |                              | 16. SOCIAL SECURITY NO.<br><u>NONE</u>                                 |                                     | 17. INFORMANT & ADDRESS<br><u>MRS RALPH HULL WESTMINSTER 94 W. GREEN</u>                                |   |  |  |
| <b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>   |                              |  |                                     |   |   | <b>18. MEDICAL CERTIFICATION</b>   |  |
| 422.1 IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>  |                              |  |                                     |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days -</u>                      |  |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C-V disease</u>   |                              |  |                                     |   |   | <u>years</u>   |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)   |                              |  |                                     |   |   |  |  |
| <b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>  |                              |  |                                     |   |   |  |  |
| 19a. DATE OF OPERATION   |                              | 19b. MAJOR FINDINGS OF OPERATION                                       |                                     |   |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) |                                     | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)  |   | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)<br>M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |                              | 21f. HOW DID INJURY OCCUR?   |                                     |   |   |  |  |
| <b>22. I hereby certify that I attended the deceased from Jan 22, 1956, to Apr 10, 1956, that I last saw the deceased alive on Apr 10, 1956, and that death occurred at 7 P.M. from the causes and on the date stated above.</b> |                              |  |                                     |   |   |  |  |
| SIGNATURE<br><u>James J. March</u>   |                              | M.D. <u>Westminster Md</u>   |                                     | ADDRESS (Street, city, town, state)<br><u>MD</u>  |   | DATE SIGNED<br><u>4/11/56</u>  |  |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |                              | DATE THEREOF<br><u>4-14-1956</u>                                       |                                     | NAME OF CEMETERY OR CREMATORY<br><u>SAMSCOPER CEM.</u>  |   | LOCATION (City, town, or county) (State)<br><u>DENNING'S MD</u>          |  |
| 24. REC'D BY REGISTRAR<br><u>James J. March</u>  |                              | REGISTRAR'S SIGNATURE<br><u>James J. March</u>                         |                                     | 25. FUNERAL DIRECTOR'S SIGNATURE<br><u>H. BARNARD TISON</u>   |   | ADDRESS<br><u>WESTMINSTER MD</u>   |  |
| DATE<br><u>4-12-56</u>   |                              |  |                                     |   |   |  |  |



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3918

## CERTIFICATE OF DEATH

03898  
74

Reg. Dist. No.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Carroll</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY                              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Sykesville</b>  |  |   |  | c. LENGTH OF STAY IN 1b<br><b>3Y 10M 29 D</b>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>Springfield State Hospital</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| d. STREET ADDRESS<br><b>112 St. Albans Way</b>   |  |   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HELEN</b> Middle <b>Weir</b> Last <b>Webster</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>12</b> Year <b>1956</b>   |  |  |  |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>W</b>              |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/27/80</b>   |  |
| 9. AGE (In years last birthday)<br><b>76</b> yrs.  |  | IF UNDER 1 YEAR<br>Months Days Hours Min. |  | IF UNDER 24 HRS.  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>at home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Ireland</b>                        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |  |  |
| 13. FATHER'S NAME<br><b>William Morrison</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Helen Weir Walker</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT Address<br><b>Record, Springfield State Hospital, Sykesville, Md</b> |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br><b>420.0</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Septicemia</b><br>DUE TO<br>(c) <b>Carbuncle on back</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b><br><b>days</b><br><b>weeks</b> |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Senile brain disease with psychosis; intertrochanteric fracture of left femur - 2/23/56</b>  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)             |  |
| 20f. (City or town) (County) (State)   |  |   |  |   |  |  |  |
| 21. I certify that I attended the deceased from <b>2/24/56</b> , 19 <b>56</b> , to <b>4/12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/12</b> , 19 <b>56</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>4/12/56</b>   |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.   |  |   |  |   |  |  |  |
| PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M. D.</b>  |  |   |  |   |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 22b. DATE THEREOF<br><b>4/14/56</b>       |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>London Park Cem.</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>                |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Wm. J. Dickner &amp; Sons - Balto., Md.</b>   |  |   |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4-10-1956</b>  |  |  |  |
| 24b. REGISTRAR'S SIGNATURE<br><b>E. Harry Keays</b>  |  |   |  |   |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 16 1956

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

03899

3919

# CERTIFICATE OF DEATH

Reg. Dist. No. 71

|  |   |  |                                    |
|--|---|--|------------------------------------|
| 1. PLACE OF DEATH  |   | 2. USUAL RESIDENCE (HOME) OF DECEASED  |                                    |
| COUNTY <u>CARROLL</u>  | STATE <u>MD.</u> COUNTY <u>CARROLL</u>              |  |                                    |
| CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>FRIZELLBURG</u>  | LENGTH OF STAY (In this place)<br><u>8 1/2 YRS.</u> | CITY (If outside corporate limits, write RURAL and give nearest town)<br>OR TOWN <u>FRIZELLBURG</u>  |                                    |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS  |   | STREET ADDRESS (If rural give location)  |                                    |
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)<br><u>ELLEN IRENE WELK</u>   |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><u>APRIL 27 1956</u>  |                                    |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>                           | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>  | 8. DATE OF BIRTH <u>1871-10-17</u> |
| 9. AGE last birthday <u>84</u> yrs.  |   | 10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                    |
| 13. FATHER'S NAME<br><u>EPHRAIM HAILEY</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>LUCINDA RUTZAHN</u>   |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO.<br><u>NONE</u>   |                                    |
| 17. INFORMANT & ADDRESS<br><u>D. FRANK HAILEY FRIZELLBURG MD.</u>  |   |  |                                    |
| 18. MEDICAL CERTIFICATION  |   |  |                                    |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| 422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>   |   | <u>2 days</u>  |                                    |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis C-V. disease &amp; Hypertension</u>   |   | <u>Years</u>   |                                    |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)   |   |  |                                    |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  |   |  |                                    |
| 19a. DATE OF OPERATION   |   | 19b. MAJOR FINDINGS OF OPERATION   |                                    |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |  |                                    |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)   |                                    |
| 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)   |   |  |                                    |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)  |   | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |                                    |
| 22. I hereby certify that I attended the deceased from <u>APR 25, 1956</u> , to <u>APR 27, 1956</u> , that I last saw the deceased alive on <u>APR 27, 1956</u> , and that death occurred at <u>1450</u> P.M., from the causes and on the date stated above. |   |  |                                    |
| SIGNATURE <u>James J. Marsh</u>  |   | ADDRESS (Street, city, town, state) <u>Westminster Md</u>  |                                    |
| M.D. <u>4/27/57</u>  |   | DATE SIGNED  |                                    |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><u>BURIAL</u>  |   | DATE THEREOF <u>4-30-56</u>  |                                    |
| NAME OF CEMETERY OR CREMATORY <u>BAUST CEMETERY</u>  |   | LOCATION (City, town, or county) (State)<br><u>Westminster R.D. Md.</u>  |                                    |
| 24. REC'D BY REGISTRAR <u>4/30/56</u>  |   | REGISTRAR'S SIGNATURE <u>Margaret R. Engler</u>  |                                    |
| 25. FUNERAL DIRECTOR'S SIGNATURE <u>Bankard &amp; Son Westminster Md.</u>  |   | ADDRESS  |                                    |

BUREAU V. S.

MAY 8 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the medical examiner or his designee. The certificate should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0390180  
Reg. Dist. No.

3920

|   |                              |   |  |  |  |   |  |
|---|------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>CARROLL</b> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>NEW WINDSOR RURAL</b>  |                              | c. LENGTH OF STAY IN 1b<br><b>YEARS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>NEW WINDSOR RURAL</b>                               |  | d. STREET ADDRESS   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>00</b>   |                              |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>PERCY CLAIRES WOLFE</b>   |                              |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>APRIL 13 1956</b>   |  |   |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>MAY 16 - 1899</b>   |  | 9. AGE (In years last birthday)<br><b>56 yrs.</b>                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CONTRACTOR</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BUILDING</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                            |  |
| 13. FATHER'S NAME<br><b>WILLIAM H WOLFE</b>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>LIZZIE GARNER</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown)<br><b>NO</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>214-14-6982</b>   |  | 17. INFORMANT<br>Address <b>RURAL NEW WINDSOR</b><br><b>AGNES WOLFE</b>  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hanging</b><br><b>974X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>minutes</b>  |                              |   |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |                              |   |  |  |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>Hanged by neck</b>                                       |  |  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br><b>6 - 4/13 1956</b><br>Hour o. m. <b>4:13</b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>Home</b>  |  | 20f. (City or town) (County) (State)<br><b>New Windsor Carroll Md</b> |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . |                              |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>James J. Marsh</b>  |                              |   |  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>   |                              |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |                              |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                              | 22b. DATE THEREOF<br><b>APR 16 - 1956</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>WINTERS</b>   |  | 22d. LOCATION (City, town, or county) (State)<br><b>CARROLL CO MD</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>DR Hartzler</b>  |                              |   |  | ADDRESS<br><b>1001 New Windsor Md</b>  |  | 24a. REC'D BY REGISTRAR<br>DATE <b>4/14/56</b>                        |  |
|   |                              |   |  | 24b. REGISTRAR'S SIGNATURE<br><b>Ernest B. Benedict</b>  |  |   |  |

BUREAU V. S.

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

|   |                              |   |                                    |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>o. COUNTY <b>Carroll</b> MARYLAND  |                              | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>o. STATE <b>Maryland</b> b. COUNTY                                 |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Sykesville</b>   |                              | c. LENGTH OF STAY IN 1b<br><b>27Y 6M 25 D</b>   |                                    |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Springfield State Hospital</b>   |                              | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |                                    |
| 4. DATE OF DEATH<br>First Middle Last<br><b>Margaret ZINKHAND</b>   |                              | Month Day Year<br><b>4 11 19 56</b>   |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/13/74</b> |
| 9. AGE (In years last birthday) yrs.<br><b>81</b>   |                              | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>John Cahill</b>   |                              | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Doyle</b>  |                                    |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>none</b>  |                                    |
| 17. INFORMANT<br><b>Record, Springfield State Hospital</b>  |                              | Address   |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of the lung</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Chronic brain syndrome associated with alcoholism</b> |                              |   |                                    |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>Months</b>   |                              |   |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              |   |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. p. m.<br><b>19</b>   |                              | 20d. INJURY OCCURRED<br>While Not while<br>at work <input type="checkbox"/> of work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I attended the deceased from <b>11/26/54</b> , 19 <b>56</b> , to <b>4/11</b> , 19 <b>56</b> that I last saw the deceased alive on <b>4/13</b> , 19 <b>56</b> , and that death occurred at <b>12:05 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br><b>Springfield State Hospital 4/14/56</b>  |                              |   |                                    |
| ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b> <b>4/14/56</b>   |                              |   |                                    |
| PHYSICIAN'S NAME (Type) <b>Agustin del Campo, Md.</b> <b>Sykesville, Maryland</b>   |                              |   |                                    |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                              | 22b. DATE THEREOF<br><b>4/17/56</b>   |                                    |
| 22c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart</b>   |                              | 22d. LOCATION (City, town, or county) (State)<br><b>German Hill Rd</b>  |                                    |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Joe J. Saker Sons</b>  |                              | ADDRESS<br><b>1318 Light</b>  |                                    |
| 24a. REC'D BY REGISTRAR<br><b>APR 17 1956</b>   |                              | 24b. REGISTRAR'S SIGNATURE<br><b>C. Harry</b>   |                                    |

MEDICAL CERTIFICATION

BUREAU V. S.

APR 17 1953

RECEIVED

Form with multiple sections and fields, including a header with "MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD" and "CERTIFICATE OF DEATH". The form contains various fields for recording death statistics, such as name, age, sex, race, cause of death, and place of death. There are also checkboxes for certain conditions and a section for the attending physician's signature.

Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FILED".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3862

## CERTIFICATE OF DEATH

## 03903

Reg. Dist. No.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Carroll</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Westminster</u>   |  |   |  | c. LENGTH OF STAY IN 1b<br><u>3 months</u>   |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>Fringer Nursing Home</u>  |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ella</u> Middle <u>M.</u> Last <u>Zumbrun</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>April</u> Day <u>1</u> Year <u>1956</u>   |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>August 5, 1864</u>                                      |  |
| 9. AGE (In years last birthday)<br><u>91</u> yrs.  |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                         |  | IF UNDER 24 HRS.<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housework</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own home</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |  |  |  |  |
| 13. FATHER'S NAME<br><u>Peter Perry</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Rachael Fox</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><u>no</u>  |  |   |  | 16. SOCIAL SECURITY NO.<br><u>none</u>   |  | 17. INFORMANT<br><u>Mrs. Edgar Hockensmith, Taneytown, Maryland</u>            |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u><br><u>422.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Arteriosclerotic C-V disease</u><br>DUE TO<br>(c) <u>  </u>   |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>years</u>                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>  </u> <u>  </u> <u>19</u>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I attended the deceased from <u>Mar 31</u> , 19 <u>56</u> , to <u>Apr 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 31</u> , 19 <u>56</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) <u>Westminster</u><br>DATE SIGNED <u>4/3/56</u><br>ACTUAL SIGNATURE <u>James J. March</u> M.D. <u>  </u><br>PHYSICIAN'S NAME (Type) <u>  </u> |  |   |  |  |  |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>April 4, 1956</u>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Union Bridge Cemetery</u>   |  | 22d. LOCATION (City, town, or county) (State)<br><u>Union Bridge, Maryland</u> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Merwyn C. Fuss</u>  |  |   |  | ADDRESS<br><u>Taneytown, Maryland</u>  |  | 24a. REC'D BY REGISTRAR<br><u>  </u><br>DATE <u>4-5-56</u>                     |  |
|  |  |   |  | 24b. REGISTRAR'S SIGNATURE<br><u>  </u>  |  |  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 9 1956

RECEIVED